An all-Wales examination of service provision for women undergoing termination of pregnancy and an examination of nurses’/midwives’ affective attributes who care for these women

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Background/rationale
Procured abortion or termination of pregnancy is an emotive issue and the care of women undergoing this procedure needs to be expert and thoughtful, giving consideration to the sensitive nature of their circumstances. The 1967 Abortion Act (amended in 1991) established the provision of legal abortion up to 24 weeks gestation under certain circumstances with no time limit in exceptional circumstances (Doyal, 1998). The number of abortions in Wales has risen steadily with 8,765 abortions performed on women resident in Wales in 2007. Eighty-eight percent of which were under 13 weeks gestation with 20% being repeat abortions.

Nurses/midwives, at the centre of care for the women involved, risk encountering public protest if they become involved in terminations and professional conflict if they refuse to participate (Johnson, 1994). These tensions add to the challenge for nurses as they support women through this difficult time (Johnson, 1994).

Procured abortion is performed via two methods. Surgical abortion involves the woman being admitted as a day case for a minor gynaecological procedure usually under general anaesthetic. The nurses on the ward provide support and care before and after this invasive procedure. Recent medical advances have resulted in 35% of abortions in 2007 in England and Wales being performed medically with strategy in place for this figure to rise (DH, 2008). Medical abortion involves two stages where the woman attends hospital to receive medication commonly administered by nurses. Following 36-48 hours, the woman returns to hospital and the second stage of medication is administered with the abortion occurring in around six hours. Although less invasive for the woman, it results in nurses being more directly involved in the termination.

Despite abortion being a common procedure, little was known about the services provided in Wales or the complexity of the nursing/midwifery role in caring for women undergoing abortion.

This research aligns with current Welsh policy of aiming for a world-class health and social care service (WAG, 2005). It also meets RCBC objectives to optimise the health and well-being of Welsh women through full engagement with frontline nursing/midwifery staff. It has contributed
to the evidence base of abortion services and assisted in stimulating innovation and best practice in this area.

**Research aim**
To explore the extent of abortion services in the NHS in Wales and examine the complexity of the nursing/midwifery role in caring for women undergoing abortion.

**The research design**
This RCBC post-doctoral research was divided into three phases:

- **Phase One** – a survey of all NHS termination services in Wales.
- **Phase Two** – a grounded theory study on a self-selected sample of nurses employed in termination services in Wales.
- **Phase Three** - a further grounded theory study based on theoretical sampling of a self-selected sample of nurses employed in termination services in Wales.
Study process

**Ethical approval**
The all-Wales scoping exercise planned for Phase One was not regarded as research according to Committee of Research Ethics Committees (COREC) guidelines as it is classed as service evaluation. However, MREC approval was required for a subsequent phase of the research and this approval was granted in March 2007. At the time of electronic MREC application (late 2006) separate NHS R&D approval was required. As a result, NHS R&D approval was gained prior to contacting all NHS Trusts in Wales for permission to conduct the study.

At the commencement of the study, the all-Wales Research Passport Scheme was still under development and therefore NHS Trust approval was required from each of the (then) 13 trusts in Wales.

MREC approval was required prior to application for R&D approval with each individual NHS Trust. Unfortunately, this added to the length of the approval process. To expedite the process, each NHS Trust R&D committee was contacted electronically and the necessary documentation requested. At the time of submission each Trust required different documentation, some requiring only the MREC forms and others requiring supplements to this. Some Trusts required an honorary contract, CRB checks and a medical and others did not. Some required the author to contact the lead clinician during R&D submission and other Trusts performed that function.

**Welsh Translation**
As the research study was being undertaken on an all-Wales basis all the major documents were translated into Welsh including the introductory letters and the questionnaire for Phase One. This was to comply with legislation and ‘sent the right message’ to make all the nurses/midwives who would be taking part feel that their contribution would be valued. As a neutral support for the participants the author drew upon the expertise of a colleague to act as an independent adviser should any of the participants have any concerns about their contribution. As well as having gynaecological and counselling expertise, she is also a Welsh speaker. Her services were not required during the research. These gestures acknowledged the importance of the Welsh language in an all-Wales study.
**Gaining access**
The challenge of gaining access differed between trusts. For some trusts, knowing the head of women’s health enabled smoother access than in others. Each trust was contacted by phone to elicit the lead clinician. One trust, in the feedback from the R&D committee, would have preferred all correspondence to be sent to ‘the trust’ rather than a named clinician, but this was considered unlikely to be productive.

The potential participants of this research study could be described as ‘closed access groups’ defined by Gilbert (1995) as those able to erect discouraging barriers or to achieve invisibility against researchers. In this case, the lead clinicians in charge of women’s health were the gatekeepers and proved impenetrable in a number of cases. Interestingly, in the three trusts where the Phase One questionnaire was not returned, expressions of interest for a Phase Two/Three of the study were received.

**Research governance**
- Letters were sent to all participants in Phase One (lead nurse/midwife), Phase Two (12 participants) and Phase Three (5 participants) thanking them for their contribution and explaining where the research would be disseminated in the future.
- All data will be stored in the University for a minimum of five years following study completion.
- A final report was sent to all Welsh NHS trust R&D departments.
Executive Summary

Phase One

Method
To elicit the extent to which services differ between Trusts, an all-Wales survey was performed whereby a questionnaire was sent to the nurse/midwife in charge of termination services in each of the (then) 13 Trusts in Wales. The questionnaire was based on current national guidelines for women undergoing termination of pregnancy (RCOG, 2004). It was designed to elicit information such as the extent of services provided including the current patient pathway from first point of contact, the number of nursing staff employed, the number and type of terminations performed. Obtaining an all-Wales perspective enabled comparison of services whilst highlighting best practice. Information obtained at this stage of the research provided background for the following stages, for women undergoing termination.

Results
The results found that none of the nine out of 10 trusts that responded had a policy on conscientious objection. Doctors in training were involved in abortions in six of the 10 trusts. All but one responding trust met the three-week target from initial referral to abortion. Five of the 10 trusts provided a dedicated abortion clinic. Only three trusts had arrangements for women with special needs such as illiteracy. Written information provided to women was of variable quality. Pre-abortion several trusts performed unnecessary tests such as cross matching and some tests necessary in certain circumstances such as hepatitis B and C were not performed.

Regarding choice of abortion method, three trusts provided medical abortion only and one trust referred most abortions out of Wales. The remaining six trusts provided both medical and surgical abortions. One trust is exploring the feasibility of first trimester outpatient medical abortions. All responding trusts complied with guidance on timing of the second stage of medical abortion. Only three trusts allowed women to administer their own medication vaginally for the second stage of medical abortion. Four of seven trusts always offered post-abortion counselling and the remaining three that responded sometimes offered the service.
Post-abortion, rhesus typing and administration of Anti D was undertaken by all trusts. Some trusts undertook unnecessary post-abortion interventions such as antibiotic prophylaxis. There was lack of compliance by several trusts in relation to administration of contraceptive supplies. Of the three trusts that did not respond, one was a major provider and the other two did not provide services within Wales.

**Conclusions**
Ten responding NHS trusts in Wales (out of 13) were measured against the RCOG guidelines (RCOG, 2004). The purpose of this study was to examine abortion services in Wales and their adherence to the current RCOG guidelines. In most cases there was adherence. In some cases, stricter adherence to the guidelines by trusts would reap clinical benefits.
Phase Two

Objectives
This study aimed to elicit some of the affective attributes in nurses and midwives involved in caring for those undergoing termination of pregnancy and explore how they may affect the care given.

Background
Nurses and midwives facing daily challenges as they care for women during the profound experience of termination of pregnancy. Recent advances have resulted in more terminations performed with the use of medication, commonly administered by nurses. With recent government recommendations, nursing involvement is likely to increase and yet little is known about the impact this will have on those involved.

Methods
A qualitative approach using grounded theory was used to compliment data collected in the first phase, providing a more personal perception of being involved in this sensitive area of nursing (Strauss & Corbin, 1990). Twelve nurses were selected via convenience sampling from nine trusts in Wales. A semi-structured interview approach was used to elicit the required affective attributes of nurses working in termination of pregnancy. The interviews concluded on saturation of data. Constant comparative analysis was used to inform the interviews as the process developed. NVivo software augmented data transcription and subsequent data coding whilst adhering to the central tenet of the researcher remaining close to the data (Polit & Beck, 2006).

Findings/discussion
Part a) Conceding and concealing judgement in termination of pregnancy
A key affective attribute was being non-judgemental, but through constant comparative analysis, the core category derived from the data revealed that nurses and midwives conceded judging the women, but concealed their judgements in order to provide care. Women undergoing repeat
termination of pregnancy was an *intervening condition* that provoked judgement. To help them conceal their judgments maxims were used such as ‘there but for the grace of God go I’.

**Part b) A woman centred service in termination of pregnancy**

The participants highlighted the *influential condition* of facilitating the woman in making her own decision rather than advocating one. This relates strongly to the *central phenomenon* of fostering woman-centred care. The participants’ strategy was to ensure that all the options were given to the woman contingent on the gestation of the foetus and the UK legal *context*. They appreciated the woman’s individual context and the relationships within it in order to build their own relationship with her. Despite the *influential condition* of a rising number of medical abortions, surgical termination was still favoured by a number of participants who felt that although there was an anaesthetic risk it was a relatively minor procedure in which the woman has little involvement and thus less emotional trauma. In *consequence* the emotional care of women undergoing medical abortion was demanding of the nurses as those closest to the women during the process.

**Conclusion**

Remaining wholly non-judgemental in such a contentious area of practice was unrealistic and unachievable for the participants in this study. Instead, they conceded judgement but concealed being judgemental in order to deliver care.

Using feminism as a methodology offered the opportunity to examine how nurses and midwives perceived their role with women undergoing abortion. The participants used their expertise to guide the women through the process so that they made the appropriate choice of whether to have a termination. It became clear that some participants had reservations about the move towards medical terminations as it highlighted the emotional impact of the procedure for the woman as well as the nurse or midwife.
Phase Three

Methods
Using grounded theory, theoretical sampling of data collected in Phase Two comprised Phase Three of this research (Strauss & Corbin, 1990). Five nurses working in one NHS trust formed the convenience sample. In the original grounded theory, conceding and concealing judgement was found to be the central phenomenon. This third phase explored how nurses cope with conceding and concealing their judgments towards women having an abortion.

Findings/discussion
Following Strauss and Corbin’s model (1990), the context of lower gestation was found to help the nurses cope, but greater nursing involvement reduced that capacity. Conceding and concealing judgment were found to be the interactional strategies. The intervening conditions were equitable treatment and this involved the nurses either treating women differently or the same depending on circumstances and their beliefs. All of these categories came to support the phenomenon of self-preservation for the nurse by ‘switching off’ and the woman’ being blasé’ (as viewed by the nurse) experiencing medical terminations of pregnancy.

Conclusion
Phase Three of this study revealed that the nurses were able to cope with conceding and concealing judgements by providing equitable treatment and by switching off thus ensuring self-preservation. The need for self-preservation and the consequences of not preserving oneself were discussed against the current literature from the nurses’ perspective and the nurses’ perception of the women’s perspective.
Phase One Report

The following section contains the report for Phase One. It has been sent to:

- Welsh Assembly Government Lead for Sexual health
- The lead nurse/midwife of each NHS trust
- R&D departments in all NHS trusts in Wales.

A briefer version of this report has been accepted for publication as:
An all-Wales examination of service provision for women undergoing termination of pregnancy

RCBC Post-Doctoral Fellowship 2006-8

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Executive summary
Abortion is a rapidly developing area and as techniques develop, more effective and efficient ways of managing the process need to be sought. The aim of this research was to establish current abortion provision, to extract examples of good practice and highlight areas of practice that require attention.

This research forms part of a two-year post-doctoral fellowship funded by the Research Capacity Building Collaboration Wales. A survey based on Royal College of Obstetrics and Gynaecology guidelines on abortion was sent to all 13 lead nurses/midwives in abortion services NHS trusts in Wales of which ten responded. Each NHS trust gave research governance approval.

In 2006, 90% of abortions in Wales were funded by the NHS and of these 32% took place in the independent sector under NHS contract compared to 86% and 48% respectively in England. As in 2005, 32% of women had one or more previous abortions. Medical abortions have more than doubled in the last five years (DH, 2006a). The average cost to the NHS of a termination of pregnancy is £827 for surgical and £568 for medical abortion (DH, 2006b).

The number and method of abortion varies between trusts depending on size of resident population and availability of method. Differences between the findings in this research and the 2005 official abortion figures may be accounted for by boundary differences and non-NHS provision.

The results found that nine out of 10 trusts that responded did not have a policy on conscientious objection. Doctors in training were involved in abortions in six of the 10 trusts. All but one responding trust met the three-week target from initial referral to abortion. Five of the 10 trusts provided a dedicated abortion clinic. Only three trusts had arrangements for women with special needs such as illiteracy. Written information provided to women was of variable quality. Pre-abortion several trusts performed unnecessary tests and some necessary tests were not performed.
Regarding choice of abortion method, three trusts provided medical abortion only and one trust referred most abortions out of Wales. The remaining six trusts provided both medical and surgical abortions. One trust is exploring the feasibility of first trimester outpatient medical abortions. All responding trusts complied with guidance on timing of the second stage of medical abortion. Only three trusts allowed women to administer medication for the second stage of medical abortion. Four of seven trusts always offered post-abortion counselling and the remaining three that responded sometimes offered the service.

Post-abortion, rhesus typing and administration of Anti D was undertaken by all trusts. Some trusts undertook unnecessary post-abortion interventions such as antibiotic prophylaxis. There was lack of compliance by several trusts in relation to administration of contraceptive supplies.

The ten responding NHS trusts in Wales were measured against the RCOG guidelines for women undergoing termination of pregnancy (RCOG, 2004). The purpose of this study was to examine abortion services in Wales and their adherence to the current RCOG guidelines. In most cases there was adherence. In some cases, stricter adherence to the guidelines by trusts would reap clinical benefits.
Recommendations for practice

- The number of medical abortions is likely to rise further in proportion to the number of surgical abortions and trust services need to be prepared to redesign abortion services to ensure they are effective.
- The number of nurses employed in primary care for abortion purposes is likely to increase as the potential of outpatient abortions becomes a reality.
- Due to the remote geographical location of a number of abortion services in Wales, it is unlikely that all trusts will all be able to provide a choice of methods. Within gestation constraints, women should be given the option to travel for their preferred method.
- A consistent approach towards involving doctors in training in abortion care and treatment in Wales is required to ensure a future supply of staff willing to participate in the procedure.
- Trusts in Wales should be strongly encouraged to provide dedicated abortion clinics.
- Development of policies for women with special needs (such as language and literacy) should be tackled at an all-Wales level for expediency.
- There is scope for the development of an all-Wales template for patient information for abortion choice with local adaptation by each trust.
- An all-Wales multidisciplinary pathway of care for abortion is recommended to encourage compliance with the RCOG guidelines and streamline care.
- It would be prudent of trusts to consider rationalising pre-abortion tests according to RCOG guidelines to increase efficiency.
- In line with greater patient involvement in care, there is scope for misoprostol to be administered by woman in more trusts.
- There is an opportunity to promote contraception to a greater extent by providing supplies immediately following abortion.
- Prompt integration of abortion care into the all-Wales sexual health strategy is commended.
Background to the study
This study is the first phase of a three-phase study examining abortion services in Wales. All phases of the study have been funded as part of a two-year post-doctoral fellowship by the Research Capacity Building Collaboration Wales. The idea for this study arose from the all-Wales Termination of Pregnancy (ToP) Network, which was tasked with developing an all-Wales ToP pathway. Establishing an up to date picture of services available within Wales was deemed an important foundation for the pathway.

The number of terminations being performed with the use of medication, commonly administered by nurses, has risen steadily since 1991 when mifepristone was first licensed for use in the UK and has more than doubled in the last five years (DH, 2006a). This development highlights recent progress made in this field and the need to capture current baseline information.

The aim of Phase One is to establish current provision in termination of pregnancy in all NHS trusts in Wales and to extract examples of good practice and highlight areas of practice that require attention.
Setting the context: The current status of termination of pregnancy

The procedure of abortion is a rapidly developing one and as the numbers of terminations steadily rise, more effective and efficient ways of managing the process must be sought. The issue of abortion is in the headlines more often than not with controversy never far away. A recent news item highlighted the lengthy wait for abortion of seven weeks in some areas of England with one woman stating

‘It just compounded all the feelings I had that I was being punished, and I deserve to be punished, almost that I should not expect a fast or efficient service, or even a kindly service’ (BBC News, 2007b)

A recent briefing paper by the British Medical Association’s medical ethics committee made several suggestions regarding abortion legislation, which may help make the service more efficient and kindly. This included the removal of medical criteria for first trimester abortion, removal of the requirement for two doctor’s signatures and more controversially supporting suitably trained nurses/midwives in performing medical abortion and surgical abortion (BMA, 2007). The parliamentary Science and Technology Committee in its recent Select Committee hearing supported the BMA recommendations as well as recommending no reduction of the maximum time limit of 24 weeks (House of Commons Science and Technology Committee, 2007).

In order to appreciate the current status of abortion in the United Kingdom the latest figures are outlined below (DH, 2006a). In 2006, the total number of abortions for England and Wales was 193,700 compared with 186,400 in 2005, a rise of 3.9%. The rate has risen steadily from eight per 1000 since 1970. The highest rate was 35 per 1000 in 19 year olds, with the under-16 abortion rate being 3.9 per 1000 both higher than 2005. The age-standardised rate was 18.3 per 1000 women, compared to 17.8 in 2005. In Wales, the rate of abortions performed on under-18s in 2006 was 17 per 1000, slightly fewer than the English rate of 18.3.

The 2006 figures reveal that 90% of abortions in Wales were funded by the NHS and of these 32% took place in the independent sector under NHS contract compared to 86% and 48% respectively in England. As in 2005, 32% of women had one or more previous abortions. Thirty percent of abortions were performed medically, more than doubling in the last five years (DH,
The average cost to the NHS of a surgical abortion is £827 and £568 for medical abortion (DH, 2006b).

Eighty percent of abortions in 2006 were performed on single women and this proportion has risen slowly since 1995. Chlamydia testing was offered to 73% of women under 25 (DH, 2006a), up from 70% in 2005 (DH, 2005). Self reported ethnicity was introduced in 2002 following revision of the HSA4 form (a statutory form required for each abortion). This revealed that 74% reported as White, 12% as Black or Black British and 8% as Asian or Asian British (DH, 2006a). In 2006, 97% of abortions were undertaken under ground C (risk of injury to the physical or mental health of the woman) with 1% under grounds A (risk to the life of the woman greater than termination) and B (grave permanent injury to the physical or mental health of the woman). In Wales 60% of abortions were carried out less than 10 weeks gestation compared to 68% in England.

With the rapid pace of progress in termination of pregnancy services, it is vital to capture the current position in order to be able to disseminate good practice and engage those areas that lack momentum and so an all-Wales evaluation of abortion services was undertaken to achieve this.

Ethical approval and research governance process
Research governance approval from each of the 13 NHS trust’s Research and Development committees was sought and obtained. Multiple sites Research Ethical Committee approval was gained for a later phase of this research, but was not required for this study as it was classed as service evaluation.

Method
A questionnaire was designed based on the RCOG Abortion Guidelines (2004) summary of recommendations together with some demographic questions regarding abortion in Welsh trusts. The study was performed in 2007 and information on number of abortions was requested from 2005. Due to time constraints and the all-Wales nature of the study, a pilot was not possible, but the questionnaire was sent to two clinical experts for review and minor changes were made. A copy of the questionnaire in English and Welsh was sent to the nurse/midwife in charge of
abortion services in each NHS trust in Wales from April to June 2007. Following three reminders, 10 out of 13 completed questionnaires were returned by September 2007. All questionnaires were completed in English. Two of the three trusts that did not respond do not provide local abortion services and all women seeking abortion are referred out of Wales and services contracted out via the NHS into the independent sector. One major South Wales trust and abortion provider did not respond.

Results
This section will outline some of the differences between trusts in Wales with regard to abortion provision. It will follow the headings in the RCOG summary of recommendations of organisation of services, information for women, pre-abortion management, abortion procedures and post-abortion care. To maintain anonymity in the relatively small geographical area of Wales a number has been assigned to each trust.

Organisation of services in Wales
The number of abortions performed in NHS trusts in Wales varies greatly and this is associated with the size of the population serviced by each NHS trust (see Figure 1 below). Trust four is currently developing its service and did not undertake any local NHS abortions in 2005, although a response was provided for some parts of the questionnaire.

![Figure 1: Number of abortions per trust 2005](image-url)
Medical abortions were most commonly performed in five of the nine abortion performing trusts, with a total of 2012 medical (57%) and 1509 surgical (43%) abortions being performed at nine of the trusts in Wales in 2005 (see Table 1 below). In 2006 the total number of surgical (58%) and medical (42%) (NHS, NHS Agency and non-NHS) abortions show that overall surgical abortions remain the most common procedure (Health Statistics Wales, 2006).
<table>
<thead>
<tr>
<th>Trust no.</th>
<th>Medical abortion (%)</th>
<th>Surgical abortion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>113 (31)</td>
<td>249 (69)</td>
</tr>
<tr>
<td>2</td>
<td>182 (28)</td>
<td>477 (72)</td>
</tr>
<tr>
<td>3</td>
<td>123 (100)</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>130 (18)</td>
<td>582 (82)</td>
</tr>
<tr>
<td>6</td>
<td>246 (100)</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>10 (100)</td>
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</tr>
<tr>
<td>8</td>
<td>991 (84)</td>
<td>190 (16)</td>
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<tr>
<td>9</td>
<td>217 (95)</td>
<td>11 (5)</td>
</tr>
<tr>
<td>10</td>
<td>208 (42)</td>
<td>290 (58)</td>
</tr>
<tr>
<td>Total</td>
<td>2012 (57)</td>
<td>1509 (43)</td>
</tr>
</tbody>
</table>

**Table 1** Medical and Surgical Abortions in 2005 performed in NHS in Wales

---

**Staffing of abortion services**

The number of consultants working in obstetrics and gynaecology ranged from three to 21 in NHS trusts. In a minority of trusts, the consultants worked in either gynaecology or obstetrics however, the majority performed both roles. The number of consultants who regularly performed abortion was fewer than the total, and in one trust, only one consultant was involved out of a total of 11 obstetrics and gynaecology consultants. Nine trusts out of 10 that responded did not have a policy on conscientious objection.

In six of the 10 trusts, doctors in training were involved in abortion with tasks including attending abortion clinic administering pessaries and dealing with complications such as excessive bleeding. Of the four trusts that did not involve doctors in training, one trust is currently developing its service.

The questionnaire asked the respondents to list the number of qualified nurses/midwives employed in the areas where abortion was undertaken (excluding the operating theatre) in both primary care and secondary care (see Figure 2 below). The number of nurses/midwives employed in secondary care is much greater than primary care. Trust 4 does not currently provide a local NHS service and trust seven did not respond to this question.
Figure 2 Nurses/midwives employed in abortion areas

Compared to nurses employed in abortion areas, the numbers of nurses/midwives directly involved in abortion is far fewer (Figure 3) which indicates that less are directly involved than employed in areas that undertake abortions. However, four trusts did not respond to part of or this entire question, which must be taken into account when interpreting the data.

Figure 3 Nurses/midwives involved in abortions
**Referral times and assessment**

The guidelines state that ‘as a minimum standard no woman need wait longer than three weeks from her initial referral to the time of her abortion’ (RCOG, 2004).

<table>
<thead>
<tr>
<th>Referral time</th>
<th>Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;14 days</td>
<td>4</td>
</tr>
<tr>
<td>15-21 days</td>
<td>3</td>
</tr>
<tr>
<td>22-28 days</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
</tr>
</tbody>
</table>

*Table 2 Referral times*

The two trusts that did not respond currently provide an out of Wales’ referral service.

The assessment appointment for women requesting abortions should be at a dedicated clinic (RCOG, 2004). Five of the ten trusts provided a dedicated clinic and the remaining five did not comply with the guidelines. It is advised that abortions should be managed as day cases in the absence of contraindications with a figure of 5% estimated as requiring inpatient care (RCOG, 2004). Six trusts stated they were able to maintain day care in abortion at least 92% of cases. In one trust, a tertiary centre, 66.7% of women were day cases. Three trusts did not respond, two of which refer most abortions out of Wales.

**Information for women**

The RCOG Guidelines (RCOG, 2004) recommend that arrangements should be in place for non-English speaking women and six trusts stated that they had arrangements. Three trusts stated that they had arrangements in place for women with special needs such as illiteracy. The majority of trusts had arrangements in place for a second doctor to consent the woman (n=8), in case the woman changes her mind (n=7), requires more support (n=6) and for women under 16 years of age (n=7). The responses were not supported by policies from any trust as requested.

The guidelines recommend verbal information is supported by written impartial, printed material preferably nationally developed by RCOG or the Family Planning Association. As requested, five trusts included written information given to women during the initial consultation and on
discharge, this varied in both content and presentation with some was presented in the trust ‘house style’. All leaflets outlined the risks of complications as per guidelines (RCOG, 2004).

**Pre-abortion management**

Although not present in the RCOG guidelines, prioritisation of women for abortion is an important issue when resources are finite. Date of referral was the most commonly used method of prioritisation in eight of the trusts with gestation used in six and method of abortion used in three of trusts. Three trusts used all three methods to prioritise. All trusts operate within financial constraints and abortions may be delayed because of this. Of the 10 trusts, only one did not list any constraints on the abortion service. Constraints cited were the availability of scan appointments, beds and theatre slots with the lack of beds being most commonly cited.

**Pre-abortion tests**

Some unnecessary tests were performed such as cross matching whilst Chlamydia, HIV, hepatitis B and C were screened in only some trusts.

<table>
<thead>
<tr>
<th>Test/procedure</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Never</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemoglobin level</td>
<td>9</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Blood grouping</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross matching</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>HIV test</td>
<td></td>
<td>1</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B and C test</td>
<td>1 (Hep B)</td>
<td>1 (Hep C)</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Cervical smear test</td>
<td></td>
<td></td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Abdominal ultrasound scan</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Vaginal ultrasound scan</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Chlamydia test</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table 3 Pre-abortion tests*
**Abortion procedures**

‘As a minimum, all services should be able to offer abortion by one of the recommended methods for each gestation band’ (RCOG, 2004: 10). Three trusts provided medical abortions only and one trust referred most abortions out of Wales. The remaining six trusts provided both medical and surgical abortions. No trusts performed surgical abortions under conscious sedation or local anaesthetic. One trust is implementing a feasibility study to determine the possibility of safe, effective outpatient medical abortions.

**Medication**

Cervical preparation is viewed as beneficial prior to surgical abortion especially if the woman is less than 18 years of age or of more than 10 weeks gestation. Of those trusts that performed surgical abortions, five always used cervical preparation, one often did and two did not respond.

Mifepristone is always administered orally. This is followed by misoprostol for which vaginal administration is recommended for the first dose (RCOG, 2004). The time interval between the administration of mifepristone and misoprostol is recommended as 1-3 days (< 9 weeks gestation) 36-48 hours (9-24 weeks gestation) (RCOG, 2004). Seven trusts stated that the time interval was 48 hours, and one trust each stated 43 and 36 hours with one non-respondent.

Only one trust used gemeprost as opposed to misoprostol. This trust only performed medical abortions for foetal abnormalities and referred other abortions out of Wales. The guidelines state that the misoprostol can be administered by either the nurse/midwife or the woman (RCOG, 2004). Six of the nine trusts that responded stated that misoprostol was always (n=5) or often (n=1) given by the nurse/midwife. Two trusts stated that it was often (n=1) or always (n=1) administered by the woman and one trust that the woman was given a choice.
Abortion aftercare
Table 4 shows compliance and some non-compliance with the RCOG guidelines for post-abortion tests and services, for example anti-D immunoglobulin G was always administered if appropriate and the majority of trusts administered prophylactic antibiotics and analgesia. However, routine histological tests were performed by three trusts, contraceptive supplies were issued sporadically and follow up appointments and counselling were not provided by all trusts.

<table>
<thead>
<tr>
<th>Service</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Never</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histopathological examination of tissue</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Anti-D immunoglobulin G (if appropriate)</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic prophylaxis</td>
<td>7</td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PRN analgesia based on pain assessment</td>
<td>8</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Sexual health advice</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Healthy eating advice</td>
<td></td>
<td>3</td>
<td>6</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>A 24-hour telephone helpline number for advice on symptoms they may experience</td>
<td>9</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Written information on symptoms they may experience</td>
<td>8</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>A follow-up appointment (OPD - consultant, nurse)</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td>4</td>
<td>3</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Contraceptive advice</td>
<td>8</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive supplies</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Immediate sterilisation</td>
<td></td>
<td>9</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 Post-abortion tests and services

When asked about the major challenges for patients responses focused on lack of theatre slots and beds for abortions, reducing the need for repeat abortions and a lack of post-abortion counselling. The major challenges for staff included safety, recruitment and retention, conscientious objection and staff training and development.
Discussion

Organisation of services in Wales
Lyons et al (2002) interpret policy as recommending at least 75% of abortion services in any area should be provided through the NHS to provide equitable access. Although this study was not able to measure this as the independent sector was not included in the survey, the Department of Health abortion statistics show that in Wales 90% of abortions are provided either through the NHS (58%) or NHS agency (32%) with only 10% classified as non-NHS (DH, 2006a). Although these figures are encouraging as they suggest improved access, the recent concerns of illegal abortions being performed in the UK should counter complacency regarding access (Haslam, 2007).

The percentage of medical abortions recorded in this study (57%) exceeded the England and Wales average (24%) in 2005. However, it should be noted that these figures do not include abortions contracted out via NHS, which were mainly surgical. The increased number of medical abortions indicates willingness by these services to embrace new ways of working. However, contracting out of some abortion services and the rurality in parts of Wales reduces accessibility, choice and could add to stress for women at a vulnerable time.

Staffing of abortion services
The majority of trusts performing medical abortions provided a primarily nurse-led service with doctors writing the prescriptions and attending any emergencies as advised by a recent Health Technology Assessment (HTA, 2005). No nurses in this study performed surgical abortions. In a US study surgical abortions provided by experienced physician assistants were comparable in safety and efficacy to those performed by physicians (Goldman et al., 2004). This possibility has been debated in the UK literature recently (Argent & Pavey, 2007; BMA, 2007). The House of Commons Select Committee also advocates expansion of the nurses’/midwives’ role to incorporate this function which will open up the debate and enhance the possibility of this issue being addressed (House of Commons Science and Technology Committee, 2007).
The number of consultants and nurses employed in gynaecology was more than those who provided abortions. With more doctors and nurses choosing to conscientiously object to the procedure a shortage of trained staff working in this area has been predicted (BBC News, 2007a; Nuttall, 2007). One way of ensuring that sufficient numbers of trained staff are willing to work with women undergoing abortion is to involve nurses and doctors during their training. All trusts accommodated student nurses in abortion care, whereas only six trusts involved doctors in training. Encouraging doctors in training to participate has been shown to improve attitudes towards abortion (Shotorbani et al., 2004) and would help to ensure that a timely service can continue to be provided in the future.

**Referral times and assessment**

Only one trust of the eight that responded was out of compliance with the time from initial referral to abortion according to RCOG guidelines (RCOG, 2004), which highlights the positive effort made to provide a streamlined service, particularly when some services are located in remote rural settings. This compares favourably with a number of international studies where barriers were found such as differing patterns of access (Ferris et al., 1998; Henshaw, 1995; Moreau et al., 2004).

Only half the trusts were able to offer a dedicated clinic for women at their assessment appointment despite this being recommended by the guidelines (RCOG, 2004). A study on women’s perceptions of abortion care found that staff being warm and friendly was vital to their positive perceptions of care (Slade et al., 2001). The women in the English study also viewed having time to put them at their ease, dealing with issues sensitively as important and it could be argued that this might not happen to the same extent in a non-dedicated clinic.

**Information for women**

Although the majority of trusts had arrangements in place for women with special needs such as the woman changing her mind or needing more support no policies were included with the response, illiteracy was poorly addressed with only three trusts having measures in place for example for illiterate women to be informed about abortion. As population literacy skills decline
in some socio-economically deprived areas addressing this issue proactively is crucial to serving women at a vulnerable time.

Only half of trusts included the written information with their responses that they provide to women at the initial consultation and the quality varied. The RCOG (2004) recommends information being impartial and based on those developed by national bodies, but no leaflet referenced national sources. Most of the leaflets contained local information and only a minority of leaflets were designed to facilitate choice. The initial consultation is considered a stressful event and the provision of comprehensive, accurate information is paramount to ensure that the woman is able to make an informed decision. A recent UK randomised controlled trial showed that although there was no difference in the method chosen, the women provided with the decision aid leaflet had higher knowledge and lower risk perception scores about both methods (Wong et al., 2006). They recommend that an evidence-based decision aid leaflet be provided preceding the initial consultation about choices of abortion.

**Pre-abortion management**

All trusts either prioritised abortions by date of referral, gestation, method or in three cases all three. Although there was a lack of scan appointments, theatre slots and beds in some trusts, the latter was the biggest constraint in providing timely abortions. The deficit of beds together with the greater cost of £259 for each surgical abortion could lead to this method being offered as a choice to women less frequently.

**Pre-abortion tests**

Some unnecessary tests were performed by some trusts. In a US study of medical abortion which ran from 1996 to 2000, of the 7000 women only four required a blood transfusion, if the results can be extrapolated to the UK it would negate the need for regular cross matching in abortion (Stephen L Fielding et al., 2001). Alternatively, some tests that should be performed based on individual risk factors to avoid the spread of HIV, Hepatitis B and C were never performed by some trusts posing a hazard to staff. An increased risk of Chlamydia means that screening should be undertaken sensitively as a systematic review of women’s views showed that information,
choice and support was important along with concerns about confidentiality, anxiety and stigma (Pavlin et al., 2006) spread of the diseases. The four trusts that never undertake cervical screening could be losing a health promotion opportunity to undertake screening and encourage the women back into the national cervical screening programme.

Although the majority of trusts comply with antibiotic prophylaxis and Chlamydia screening there remains room for improvement. Chlamydia screening needs to be undertaken sensitively as a systematic review of women’s views showed the need for information, choice and support was important along with concerns about confidentiality, anxiety and stigma (Pavlin et al., 2006). Viewing abortion as part of the integrated sexual health strategy may help trusts to appreciate the broader perspective of ensuring the future of women’s sexual health (DH, 2001).

**Abortion procedures**

In six trusts, women were able to choose which method they underwent, depending on gestation. The issue of choice in abortion is a recurring theme in the literature. The RCOG guidelines advocate a minimum of one, and ideally a choice, of the recommended methods for each
gestation band (RCOG, 2004) (Figure 4).

![Gestation (weeks from date of last menstrual period)](image)

**Figure 4 Abortion methods in UK according to gestation band (RCOG, 2004)**

Both methods have advantages and disadvantages and one will suit some women more than it will suit others. Ho (Ho, 2006) reviewed women’s reasons for choosing medical or surgical abortion and these included the perception that medical abortion was safer, more natural and convenient whilst surgical abortion was perceived as taking less time, reduced awareness and was also viewed as convenient. A Danish study that randomised some women and gave others the choice between methods, found that satisfaction with both methods is high and higher when given the choice (Rorbye et al., 2005). Doubtless the greater cost of surgical abortion will influence provision of care (DH, 2006b).

Conscious sedation is considered to be safer than a general anaesthetic (DH, 2002). Guidelines have been available for this procedure since 2002, but it requires a skilled sedationist and no
trusts in this study performed surgical abortions using this or local anaesthetic. The effectiveness of local anaesthetic has been called into question by a recent study (Suliman et al., 2007) which found high rates of post-traumatic stress disorder in those undergoing surgical abortions, particularly those receiving local anaesthetic.

One trust in Wales is currently exploring the feasibility of outpatient medical abortions in the first trimester via a pilot study involving careful screening of potential participants. A recent pilot project in the South of England has shown that abortion can be safely performed outside hospital under controlled conditions (BBC News, 2007c), although in the UK previously there has been a reluctance by women to undertake self-administration at home (Hamoda et al., 2005; Kiran et al., 2006). Nevertheless US and Canadian studies show that in the right circumstances outpatient medical abortions can be successful (Shannon et al., 2006) (Eric Schaff, 2006; EASchaff et al., 2000). By excluding the second stage of early medical abortion from the definition of ‘carrying out an abortion’ a trial of this category of medical abortion has been recommended (House of Commons Science and Technology Committee, 2007).

**Medication**

Allowing the woman (as opposed to the nurse) to administer vaginal misoprostol only occurred in two trusts. Nevertheless in a recent research study it was shown to be 100% successful with attendant patient satisfaction (Kiran et al., 2006). Allowing this simple form of patient participation would return some control to women and could increase their sense of involvement and responsibility for their own health.

All trusts complied with RCOG guidelines regarding the time interval between mifepristone and the prostaglandin for medical abortion. A review (Eric Schaff, 2006) based on five randomised controlled trials claims that the interval can be reduced from 48 to 24 hours without loss of efficacy and further recommends that there is sufficient evidence to reduce the time to 6-8 hours. However, the results of a randomised controlled trial comparing misoprostol either six hours later or 36-48 hours after mifepristone (Guest et al., 2007) showed less efficacy at six hours. On this basis, reducing the time interval between stages in medical abortion may proceed with caution.
Based on the evidence, the sole trust using gemeprost instead of misoprostol would need to justify its continued use as the guidelines recommend misoprostol as a cost-effective alternative to gemeprost (RCOG, 2004). A study comparing efficacy of both products found the mean cost per patient to be US$1.48 for misoprostol and US$85.79 for gemeprost (Azlin et al., 2006). A study comparing gemeprost to vaginal misoprostol in first trimester abortions found both to be equally effective (2005).

**Abortion aftercare**

Rhesus typing was always performed by all trusts and Anti-D immunoglobulin G administered as per guidelines (RCOG, 2004) although there is little evidence that sensitisation could occur under 63 days gestation (von Hertzen & Baird, 2006). Although routine histological testing of tissue is deemed unnecessary, in the three trusts where this took place as many abortions were undertaken solely for foetal abnormality.

Antibiotic prophylaxis was only provided sometimes by two trusts despite guidance stating this is a minimum requirement to prevent both short and long term detrimental effects (RCOG, 2004). Compliance with the guidelines on analgesia was evident in the majority of trusts where administration was based on patient need and pain assessment.

Contraceptive advice was always issued by most trusts but in never providing supplies two trusts missed opportunities to check that women have adequate contraception immediately following abortion (RCOG, 2004; von Hertzen & Baird, 2006). In a US study the majority of participants were not using contraception at the time of conception (Goss, 2004) and so offering supplies immediately following abortion, may make the difference between abortion being an isolated occurrence and becoming a repeat event.

Post-abortion counselling is recommended as being available for the small minority of women who may require it (RCOG, 2004) and as far as can be ascertained this is the case in Wales. In a recent phenomenological study an attempt was made to gain insights into a complex situation
(Trybulski, 2005) and the evidence on whether counselling positively influences long term outcomes is by no means certain (Fergusson, 2006).

A major limitation of this study was the questionnaire design as the aim was to capture the maximum amount of data whilst keeping it a simple as possible. Inevitably, the quest for the maximum amount of data overrode simplicity and some data could not be analysed due to ambiguity of question design. In hindsight, piloting the questionnaire using an English NHS trust would have minimised these difficulties. Comments made by respondents on this point have been taken note of by the researcher who is grateful for their perseverance in completing the questionnaire.

**Conclusion**

The RCOG guidelines were first introduced in 2000 and have since been updated (RCOG, 2004). A further update is recommended via the National Institute for Health and Clinical Excellence (House of Commons Science and Technology Committee, 2007). The purpose of this study was to examine abortion services in Wales and their adherence to the guidelines.

Of all the recommendations provide by the guidelines (RCOG, 2004) the majority of the trusts complied with the majority of them. The guidelines are in place to promote best practice and improve the quality of the service, but require that each trust interpret them according to local circumstances, professional judgement and individual patient need.

There is room for improvement in adhering to the guidelines by some trusts and indications of where this would reap the most benefit can be found in the recommendations for practice. In some instances, compliance may have resource issues such as providing a dedicated abortion clinic. However, the extra resources necessary could be offset against unnecessary tests and investigations that are performed in some instances.
Acknowledgements

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References

See end of document.
Phase Two

Phase Two comprised a grounded theory study, which resulted in several different perspectives being explored. Phase Two is divided into two sections that form two stand-alone academic papers which have been submitted and accepted for publication respectively:

- Conceding and concealing judgement in termination of pregnancy: a grounded theory study.

- A woman centred service in termination of pregnancy: a grounded theory study.
Background

In a recent House of Commons Science and Technology Committee, the scientific developments relating to the 1967 abortion act were examined. Evidence was heard from a range of experts on a number of issues including the nurses’ role (House of Commons Science and Technology Committee, 2007).

The government response to the Committee recommended an increase in nurses’ responsibilities in abortion care and treatment (Secretary of State for Health, 2007). This would include, subject to appropriate training, prescribing the abortifacient for medical abortions and performing early surgical abortions. These increases in responsibilities would require a change in legislation, but based on international evidence the view was taken that ‘the expansion of the nurses’ role would be safe, effective, acceptable to patients and would significantly improve access to abortion services’ (Secretary of State for Health, 2007: 8).

Allowing early (first trimester) medical and surgical abortions to be nurse-led also has the support of the British Medical Association (BMA, 2007). In addition to the expanded role that many nurses now take in early medical termination of pregnancy, these reports all point towards nurses/midwives taking a lead role in early surgical abortions. Nurses have previously taken on this challenge in many specialist areas, but caring for women in gynaecology and specifically in intentional and unintentional pregnancy loss has a heavy emotional burden.

Literature review

There is a lack of research examining the attributes needed by nurses working in abortion care in the UK, particularly in light of the current rise in the numbers of medical terminations and increased nursing involvement. In first trimester medical abortion instead of being able to distance themselves from the termination by classing it as a minor surgical procedure performed by others, nurses/midwives remain with the women as the medication takes effect and the foetus is expelled. This intensive type of involvement in such a profound event requires certain affective attributes which this study sought to elicit. Identifying some common affective
attributes will provide a baseline from which further research can be undertaken as the nurse/midwife contribution increases.

A qualitative study by Bolton (2000) in gynaecology found that nurses gave the ‘gift’ of their emotional labour to the patients. McCreight (2005) studied perinatal grief in unintentional loss and recognised the challenges of the nurses managing their emotions alongside those of the woman. A mixed method, South African study attempted to capture the effects of abortion on nurses in the first year of legalised abortion (Poggenpoel et al., 1998). It found amongst other things that they would like to be able to choose whether to be involved and that they felt turmoil regarding life and death.

A Swedish qualitative study (Alex & Hammarstrom, 2004) analysed women’s experiences of induced abortion from a feminist perspective and found that despite positive attitudes towards abortion generally the women held negative attitudes towards their own abortion. The researchers advise that nurses and midwives need to be aware of the women’s complex experiences with abortions in order to be able to support and empower them. It could be argued that firstly the nurses/midwives need to be cognisant of the effect of their own intense involvement in such complex experiences to be able to assist the women.

Intense involvement by nurses and midwives has been termed emotional labour and has been the subject of research and commentary (Bolton, 2000; Hemmerling et al., 2005; McCreight, 2005; McQueen, 1997; Phillips, 1996; Smith, 1992). In a qualitative study by Bolton (2000) examining nurses on a gynaecological ward emotional labour was classed as a gift given freely to the patient. McCreight (2005), in her study of perinatal grief through unintentional loss, emphasised the challenges of nurses simultaneously managing their own emotions alongside those of the women.

There has been an increase in medical relative to surgical terminations in the UK and USA. The number of terminations in the UK being performed with the use of medication, commonly administered by nurses, has risen steadily since 1991 when mifepristone was first licensed for use in the UK and has more than doubled in the last five years (DH, 2006a). The move from
surgical to medical terminations has meant that nurses are becoming more directly involved in terminations. A recent House of Commons Scientific and Technology Committee (2007) recommended that nurses should take a more prominent role in both medical and surgical abortions which would further increase their involvement and responsibilities in this procedure.

A US exploratory study (Joffe, 1999) comprising interviews with 25 long term surgical abortion providers asked about the transition to medical abortions and found that most viewed it as an acceptable innovation without the complications of haemorrhage that they had feared. In Australia the move towards more medical terminations has been more haphazard (Calcutt, 2007; RANZCOG, 2005).

Despite the satisfactory safety record of medical abortion (Say et al., 2002), for a woman to undergo the procedure it currently requires the nurse or midwife to be there and experience it along with the woman (Huntingdon, 2002). It is unclear how increased involvement will affect the dynamics of the nurse/midwife-patient relationship or their involvement in the long term.

**Aims of the study**
The aims of the study were (1) to determine the affective attributes of ToP nurses/midwives and (2) to explore how the attributes affect care given by nurses/midwives involved.

**Method**
Grounded theory was chosen for this research because it allowed exploration of an emerging situation in ToP care. Early medical termination of pregnancy (EMToP) is a relatively new phenomenon and has been introduced in most trusts in the last decade. The effects of the greater involvement of nurses/midwives in care and treatment of ToP patients has not been explored to any great extent making grounded theory an appropriate method for the study of these issues, helping to make sense of its social processes and social structures (Polit & Beck, 2006). ‘The grounding of theory can be considered as an authentic, open means of achieving a comprehensive description of a given situation or events prior to analytical closure through the formulation of a theory or set of theories’ (Brown et al., 2003). The specific attraction of
grounded theory was its pedigree; combining the qualitative approach of Strauss and the quantitative background of Glaser (Strauss & Corbin, 1990). This was a method developed to put a systematic slant on what could otherwise be a chaotic experience. Nevertheless the intellectual creativity necessary in analysing data grounded in practice is highly valued in this approach (Strauss & Corbin, 1990) making it a suitable method for this study.

**Methodology**

King (1994) differentiates method as the mechanical way in which data are collected as compared to the underpinning epistemology or methodology. Symbolic interactionism is used to underpin this grounded theory study. It was founded by George Herbert Mead and then defined and refined by Herbert Blumer (1969). It is centred at the individual rather than the societal level and it aims to explain the meanings of interactions between actors, their actions and the actions of others (Porter, 1998). For example, we attach cultural significance to the process of ToP even though the process of undergoing a minor medical procedure could be applied in many different situations. The meaning of this process to those who care for women undergoing ToP has been symbolically constructed in a very different way to any other minor procedure. The symbols associated with ToP were interpreted by the participants in this research (Porter, 1998). Although synonymous with grounded theory, the application of symbolic interactionism was held in abeyance until data analysis was nearing completion to avoid premature conceptualisation (Polit & Beck, 2006).

**The participants**

Letters were sent to all nurses/midwives involved in ToP to all NHS trusts in Wales via the nurse/midwife lead. Twenty-seven women expressed an interest in participating in the research. The decision of who to interview was made on a purposive basis ensuring a reasonable geographic and trust spread (O'Leary, 2005). Homogenous sampling was used which enabled the ToP subgroup to be accessed (Norwood, 2000). Qualitative sampling is often criticised for being biased (Norwood, 2000) and yet that is the intent as choosing the sample carefully allows a greater potential for data saturation (Morse, 1995).
Twelve participants were purposively chosen from nine of the 13 trusts in Wales. They were chosen as the study progressed allowing the study direction to be guided by the initial findings (Parahoo, 1997). The participants chosen were viewed as being able to contribute substantially to the research as they were experienced in the field of gynaecology and termination of pregnancy ranging from 10 to over 30 years experience. There were five nurse/midwife specialists, one midwifery practitioner, two family planning nurses, three ward sisters and a ward staff nurse. The educational background of the participants varied from being graduates to having received very little post-registration education. Four of the participants were known to the researcher on a professional basis prior to the interviews. All potential participants, who expressed an interest but were not recruited, were contacted and thanked for their offer to participate.

**Ethical and research governance issues**

Prior to the study ethical approval was obtained by the UK NHS Multiple site Research Ethics Committee (MREC) and the Research and Development committees for each NHS trust in Wales. Due to the sensitive nature of the topic and the potential for discomfort of the participants and the researcher strategies were put in place to deal with this. For example, the telephone number of a Welsh-speaking academic colleague with ToP expertise was given to all participants to enable debriefing following the interviews. The researcher had a number of identified clinical and academic colleagues to approach for debriefing within confidentiality guidelines. To enhance flow and anonymity, the term ‘nurse’ has been used to include all of the participants and their specialities. Direct quotes have been identified by interview number to protect the participant’s identity.

**Data collection**

Data were collected by individual interviews using a semi-structured questionnaire (Appendix 2), which were held in a location of the participant’s choice at a time convenient for them. An MREC approved topic guide was used as a prompt for the interviews. The stem question was ‘what attributes do you consider important in a nurse/midwife dealing with women undergoing termination of pregnancy?’ Each interview took between 40 minutes and one hour. All interviews were audio taped, with permission, using a digital recorder. This allowed the
interviews to be stored digitally on the computer, which the researcher transcribed verbatim. Anonymity was assured and all data were stored according to UK national research guidelines.

Grounded theory demands sensitive interpretation of complex data and ways of rigorously exploring themes and discovering and testing patterns and NVivo 7 was used to assist in achieving this.

**Data analysis**

Data were collected and analysed concurrently using constant comparative analysis (Strauss & Corbin, 1998). Initially 48 open codes were established from the data. This served the purpose of fracturing the data (Boychuk-Duchscher, 2004) allowing identification of categories and subcategories of which 10 were initially derived. As the interviews progressed, theoretical sampling revealed concepts repeatedly present that had theoretical relevance resulting in 25 open codes that were incorporated into seven axial codes. Eventually no new categories were found which was consistent with data saturation (Charmaz, 2006). Intra-axial coding (Tables 1-4 p 65-70) was then performed followed by inter-axial coding (Tables 1-4 p 65-70). Selective coding then provided the platform for integration of the categories and selection of the core category or central phenomenon of ‘conceding and concealing judgements’ (Figure 1 p65).

A major criticism of qualitative studies is that they do not meet the scientific rigour of quantitative research specifically that of validity and reliability (Horsburgh, 2002). Although the exact methods for ensuring rigour may have differed, this study aimed to meet standards of credibility recognised by qualitative researchers.

**Validity**

This refers to the confidence with which one measures what one sets out to measure (Appleton, 1995). Appleton (1995) suggests using the term credibility to verify whether the research data and findings are accurate. Participant validation (or credibility) occurred after transcription where a copy of each individual’s transcript was sent to all participants for data verification. Morse argues that it is not appropriate to expect participants to have the ability to validate the research findings (Morse, 1998). The credibility of data analysis was enhanced via discussions with a peer mentor who challenged the coding process helping to strengthen the endeavour. At the point of selective coding and development of the core category a colleague who had recently
completed a PhD using grounded theory was enlisted to ensure rigour of coding during these stages.

External validity relates to generalisability of a study’s findings. If the findings cannot be generalised then they are arguably of little use (Horsburgh, 2002). Horsburgh (2002) argues that it is worth considering the extent to which the theory derived from one study may be able to provide explanations for people in other situations as a remedy for generalisability in qualitative research. For instance, the grounded theory in this study may help to provide an explanation for others caring for such patients, but this does not mean that the findings can be universally generalised.

**Reliability**

In qualitative terms reliability refers to consistency, repeatability, replicability and clarity of a study and a study can be judged as reliable if the reader can follow a decision trail (Appleton, 1995). Describing the process of how the grounded theory was generated in addition to the Tables 1 to 4 (p65-70) and Figure 1 (p65) has illuminated a decision trail, although word limit precludes further detail.

**Part a) Findings**

As can be seen in Figure 1 (p65) the model based on the emerging grounded theory is complex and due to the large amount of data from the original study, the results have not been replicated in full. Many affective attributes emerged during the interviews. Those most commonly cited were being a good listener and being open-minded. However, being non-judgemental was cited by all but one participant as a necessary attribute and the core category of ‘conceding and concealing judgements’ was developed from this. The participants conceded that judgements were provoked particularly by ‘repeat ToP’, a major intervening condition. The ‘use of maxims’ was used as an interaction strategy to counteract the participants’ judgements and enable concealment. The author takes responsibility for selecting and editing the material and acknowledges that omissions may be of equal of greater significance to the theory (Horsburgh, 2002).
Conceding judgements
The core category was derived gradually from the data, as analysis was undertaken. Although not a core category initially, as the interviews progressed it became clear that all of the participants were keen to cite being non-judgemental as a founding attribute of the ToP nurse. They were unequivocal in their views; this attribute was non-negotiable

‘I think really you have got to have an open mind really. And be non-judgemental really. You can’t judge them really because they have all got different backgrounds and they have all got different histories behind them, social backgrounds, you know’ (Interview 3).

‘You’ve got to be non-judgemental that’s one of the biggest things and even though you might be shocked at time you’ve got to go in without any shock on your face really’ (Interview 10).

As some of the initial interviews were transcribed and analysed the claim for being non-judgemental began to conflict with what was being said. Without exception and perhaps unsurprisingly all of the participants judged the women they cared for

‘You know people having intercourse not using contraception, well what do you expect? I love it when they write in ToP clinic ‘unfortunately has found herself pregnant. It tickles me because I think what do they expect?’ (Interview 4).

‘Some of them look on it as a form of contraception. But that’s mainly the social terminations’ (Interview 10).

Concealing judgements
Although being non-judgemental was seen as a fundamental attribute for someone caring for women undergoing ToP, when pressed on how that can happen in reality the participants were less clear. A number recognised that they do in fact judge all the women who attend for ToP but that the judgements must be concealed from the women

‘I’m not saying we don’t talk when they’ve gone, but you can’t be judgemental to them at the time, they must feel that you know? They are not to be judged’ (Interview 11).

To express this concealment terms such as ‘putting it to one side’ and ‘keeping it back here’ were used. Interestingly in some instances, not only did they conceal their judgments, but they also defended the women against the judgements of others
‘To me it’s a big decision; it’s their (the women’s) decision. They can do without people being sanctimonious, or being funny to them. You know they come to the ward and they never say ‘I’ve come for my termination’ only one person said that to me. They say ‘I’ve got an appointment for eight o’clock’ or ‘I’ve come here for a procedure’. They’ll never use the word termination’ (Interview 4).

The quotes above and below also highlight the disempowered vulnerability of the women attending for ToP with regard to being judged for undergoing a ToP

‘We have got assault victims here which I think is another reason why this service is very important. To support them through a decision that they don’t want to have to make, but they make because of the situation at home’ (Interview 4).

It has been established that the participants conceded and concealed their judgements from the women, but a major intervening condition that provoked judgement was repeat terminations.

**Repeat terminations of pregnancy**

Despite an initial claim of being non-judgemental, the majority of participants expressed judgement over women using the ToP service multiple times although there was an undercurrent of sympathy for these women

‘I know some of them come back year after year for ToPs and I don’t agree with that to be honest with you. But, erm you give them the benefit of the doubt and there are some tragic circumstances with some of them you know. I feel sorry for a lot of them’ (Interview 3).

In some cases there was concern that the ToP services had failed them

‘It gets a bit frustrating. Because you think ‘what are we doing wrong from our point of view’? Or is it just that we are giving the information and we are trying our hardest with contraception etc but it just isn’t. You can take a horse to water but you can’t make it drink sort of thing’ (Interview 7).

Overall, it appeared that the number of recurrent ToPs was low, but that those who attended the service more than once tended to have multiple ToPs

‘I just feel numerous abortions oh woah now, I just feel a bit, perhaps are we doing our job properly then, if they are coming back for abortion after abortion after abortion?’ (Interview 11).
Use of maxims

To enable concealment of judgements made, the participants used maxims. A maxim is a saying, or statement accepted on its own merits often with a supporting moral message. The personal backgrounds of the participants together with their professional experiences enabled them to conceal their judgements and empathise with the majority of women. A number alluded to their own circumstances in an effort to show that it could happen to anyone

‘We have all got children of our own and it could happen on anybody’s doorstep’
(Interview 3).

One sums it up in relation to the use of her own service

‘I think in my head ‘there is no way on earth I would have an unplanned pregnancy’, but I’m sure lots of these women thought that’ (Interview 12).

Another referred to a case she had been involved in when a woman had received a back street abortion. The participant appeared to use this as her paradigm case against which she judged her future actions in ToP with use of a specific maxim

‘This (case) is why, there but for the grace of God go I or whatever’ (Interview 1).

Maxims such as ‘do as you would be done by’ were used by several participants, which intimates that they empathise with anyone who may need a ToP in particular circumstances

‘I put myself in that situation and I would want somebody to be supportive of me and I treat these ladies as I would want to be treated in that situation’ (Interview 6).

The two maxims arise from the duty based theory of Kant with its emphasis on obligation towards treating others with equal respect (Johnson, 2005).

Discussion

Conceding and concealing judgements

The results show that when asked the participants claimed that being non-judgmental was a key attribute for a ToP nurse. However, as the interviews progressed, and via constant comparative analysis, the participants conceded judgement particularly in cases of repeat ToP. However, they also revealed strategies to conceal their judgements such as the use of maxims.
There has been some consideration in the nursing literature of the importance of being non-judgemental, but there is little guidance on how nurses can deal with the judgements they may make. Koh (1999) argues that non-judgemental care is a professional obligation whereas Hayter (1996) asks whether non-judgemental care is possible particularly in relationship to nurses’ attitudes towards patient’s sexuality. Hayter presents both sides of the debate and cites Goldsborough (1970) in claiming that being non-judgemental does not mean giving up personal beliefs or changing them to fit with others, it is being aware of their values and the importance of them within their professional relationship with patients. The nurses in this study seemed to subscribe to Goldsborough’s claim in having their own judgements, recognising them and concealing them for the sake of their professional relationship with the patients. This is in contrast to McQueen (1997), in her qualitative research on emotional work in gynaecology nursing where she claims that nurses caring for women having a ToP seem to avoid considering the patients’ circumstances and suspending their judgement.

Bolton (2005), in her longitudinal, qualitative study of gynaecology nursing, conversely found that some nurses were judgemental between themselves and were unable to conceal their judgements being observed as more abrupt in their dealing with some ToP patients. This did not seem to be the case in this study as the participants concealed their judgements in various ways. Some used maxims to overcome judgement and others associated women undergoing ToP with vulnerability and being victims.

The issue of conceding and concealing their judgements as well as viewing some women as victims led to a consideration of Goffman’s work on stigma (1963) as abortion remains heavily stigmatised. Stigma originally referred to a brand or mark on Greek slaves, separating them from free men. It is now commonly used to denote a disgrace or defect (Gray, 2002). Even in today’s relatively liberal society obtaining a termination of pregnancy is considered by some to be a disgrace (Major & Gramzow, 1999).

A longitudinal study of 442 women by Major and Gramzow (1999) found that women who felt stigmatised by abortion were more likely to keep it a secret. The associated suppression of thoughts correlated positively with increased psychological distress over time. The need to
conceal judgements could be argued to be of even greater importance in adolescents as a recent study found that a significant proportion of pregnant adolescents felt stigmatised (Wiemann et al., 2005).

The term stigma was only used by one participant but it was evident in the data, for example, one participant described women avoiding the phrase ‘termination of pregnancy’ when entering the service. This behaviour can be translated into ‘felt’ stigma in which the woman described would have been feeling ashamed and expecting discrimination (Mak et al., 2007). In fact the participant specifically defended women against ‘enacted’ stigma where unfair behaviour (being sanctimonious) by others was experienced (Scambler, 1998). This chimes with symbolic interactionism, which claims that meaning arises from the process of interaction between people (Blumer, 1969). Thus, the meaning of ToP for the participants transfers to the women through their interactions with by concealing their judgements they reduce the felt stigma.

Symbolic interactionism proposes that by taking the view of others we can see ourselves as they do (Camp et al., 2002). Those attending for ToP fall into the third category of socialisation as defined by Goffman (1963) as they are newly stigmatised and must now view themselves as being part of a subgroup that, in the view of others, they may previously have renounced.

**Repeat ToPs**

The major intervening condition that influenced the nurses’ judgement was repeat ToPs. Interestingly, although the participants tended to be more likely to judge the women undergoing repeat ToPs they also questioned what they might be doing wrong in allowing this to reoccur. To interpret this through symbolic interactionism, the meaning that the participants attached to repeat ToPs was to judge the women, give them the benefit of the doubt and to judge their own performance.

Jeffrey (1979) used Talcott- Parson’s sick role criteria to measure the legitimacy of casualty patients and when employed in this research it seems that ToP fails to meet the standards of the sick role in two of the four criteria: patients must not be responsible for their illness and they must be restricted in their reasonable activities. This has implications for how society views the
need for ToP for example if the woman could have avoided her condition and thus the sick role, by using contraception then there is likely to be less sympathy for administering treatment thus stigmatising it further.

In this study, all of the participants viewed women as having a legitimate call on the sick role with the exception of those undergoing repeat ToPs. For example, in the sick role patients must not be responsible for their illness and must rely on health professionals for getting better. Overall, the participants did not hold the women requiring ToP responsible and they were accepted into the sick role by being admitted into the service. By requiring repeated ToPs these women demonstrated, by not heeding previous advice, that they could indeed be held responsible for their condition. Women who had to access the service repeatedly for ToP were also not seen to be restricting their ‘reasonable activities’ (Jeffrey, 1979), in this case using contraception when having intercourse.

Co-operation with health care professionals to regain health is also expected of those in the sick role and for the ToP nurses this came in the form of contraceptive advice. Patently, those who accessed the service a number of times for repeated ToPs were not cooperating. Compounding this were those women who acted in a blasé manner being dismissive of the participants’ offers of help, thereby not cooperating with them to regain their health.

**The use of maxims**

The use of maxims seemed to move the participants from conceding to concealing judgement and helped the participants to identify with the women attending the service. The participants were saying that it could happen to anyone, even them. This close alliance to the women could be described as possessing an ‘affiliate stigma’. This describes the identification of individuals closely associated with the stigmatised (Mak et al., 2007). Using Goffman’s (1963) terminology, affiliate stigma also acknowledges the nurses as ‘the wise’. The wise are those intimately involved in the lives of those with a stigma, which have empathy and understanding of the predicament of those requiring ToP. The wise also accept faults within themselves (Younger, 1995) or recognise that needing a ToP could happen to anyone echoing the participants’ maxim of ‘there but for the grace of God go I’.
Becoming wise requires a right of passage, which may be via ‘a heart-changing personal experience’ (Goffman, 1963: 41). Many of the participants iterated events which had made them view ToP more favourably some of which had changed their career path such as witnessing the results of an illegal ToP. This process of interpretation of a situation is central to the use of meanings in symbolic interactionism (Blumer, 1969). To become wise the nurse must not only offer herself to women undergoing ToP, but she must also be accepted by them in order to accept them unconditionally (Goffman, 1963). This is where the expertise of the nurses comes into play. Indeed, many of the participants found that as they shared their experience the women saw her as credible and the options and advice that she gave the women allowed them to make the right choices thus validating the nurses’ wisdom.

There are several implications for practice arising from this study. Firstly, if being non-judgemental is an aspiration and can never be wholly achieved then acknowledging and dealing with judgements may be a more honest way forward. Acknowledged judgements could then be discussed in a professional environment such as clinical supervision where strategies could be devised for nurses to conceal their judgements in an insightful, considered manner. Abortion remains a stigmatised area of practice, which was implicit in many of the participants’ comments and in their efforts to conceal their judgements. In order to minimise stigma in practice nurses need to devise ways of normalising ToP within the health care system commencing with debate in a supportive environment such as clinical supervision.
Part b) Findings

In this section, the data will be examined in relation to the strategy of facilitating the decision, and the context and influential conditions of the decisions made, as well as the consequences of how nurses cope with women undergoing medical terminations of pregnancy. All of these categories articulate with and support the central phenomenon of fostering a woman-centred service, which will then be discussed in relation to its impact on nursing (Figure 1 p 65).

Facilitating the decision

A strategy employed by the participants was to facilitate the woman’s decision-making rather than assuming that an abortion was the chosen option (Figure 1). A woman’s decision to terminate her pregnancy was considered a profound one by the participants. It was also deemed to be a decision likely to affect her implicitly or explicitly for a significant length of time. Some participants were working at the initial stages of the termination of pregnancy service and in some cases the woman may not have made her decision, or may be thinking of reversing it:

‘I think that they weren’t really sure in the beginning, but let’s take the appointment anyway and see what happens and when they see the counsellor they decide that it’s not the right decision for them and they would actually like to continue with the pregnancy and that’s fine and they go away and that’s lovely you know, not a problem’ (Interview 2).

‘even though they have been counselled in the pregnancy advisory clinic some are very unsure. Those who are very unsure nine times out of ten they’d ring up and say ‘look we are going ahead with the pregnancy’’ (Interview 3).

Many of the participants acknowledged that it was the woman’s situation that led them to seek an abortion. Given other circumstances, some women may have chosen to continue with the pregnancy.

The decision in most cases will have been a difficult one to make and the nurse may have been involved from this point in the woman’s care:

‘it’s the biggest decision that a woman ever has to make, to have a termination. So I don’t think people come to that decision lightly you know’ (Interview 4).
'I used to leave the day with a headache. I think that's most to do with the fact that you are very mindful of the situation, or their circumstances and very mindful of what you are saying to these women because number one you don’t want to influence their decision and number two upset them any more and make the decision any harder than it is in the first place’ (Interview 5).

The above participant highlights the goal of facilitating the woman’s own decision-making rather than advocating a specific decision. This approach relates strongly to the central phenomenon of fostering woman-centred care.

**Appreciating the context**

A number participants acknowledged that the women made their decision in terms of their own current circumstances. This was both an influential condition as well as providing a context for care (Figure 1):

> ‘At the end of the day it’s their decision and I feel like that the decision that they make today is the right one for them at this time, you know’ (Interview 11).

> ‘It’s not necessarily that the women who attend the service want to have an abortion I just think that at the time at that specific moment in their life it’s something that they have to do for one reason or another’ (Interview 5).

Rather than being autonomous in their decision making, the participants spoke of the women who were ‘tied’ into relationships with others, be it their partners, parents or other children, and their relationships helped shape their circumstances and thus their decision making (Allmark, 1995). The participants recognised that they had to appreciate the woman’s individual context and the influential condition of the relationships within it in order to value the woman’s decision as her own.

The participants’ expertise allowed them to offer the appropriate options as well as pertinent and timely advice, which in the majority of cases led to timely decisions made by women. However, it was acknowledged by some that the decision made was heavily dependent on current circumstances:

> ‘I only know what she tells me, she’s making a decision based on what ever’s going on in her life now you know? And I just sort of think well if it’s not right for her now, then it’s not right for her, that’s her decision you know?’ (Interview 12).
The above example shows that should the decision have been made in other circumstances or at another time, it may very well have been a different one.

**Coping with medical termination**

A further influential condition was the number of medical abortions which are rising in the UK (Department of Health, 2006). They are known to be safe, effective and efficient (Rorbye et al., 2005). However, the participants had varying opinions of medical termination. For some it was seen ‘as going through the process’ whereas surgical termination could be viewed by the women and even the nurses as a minor gynaecological procedure such as a dilatation and curettage (D&C). One participant hypothesised that ‘going through the process’ may limit the numbers returning for repeat abortions:

‘Yes, if they’re typically a patient on the gynae ward that’s had pain, that’s bled, potentially seen this foetus, and lots of them do, they seem to be, oh, I don’t know, we don’t tend to have many of those coming back for a repeat termination... In some ways it’s good if somebody’s been through that process they know exactly what’s happened, they’ve seen it was a baby, but then is it a form of punishment? (Interview 12).

Viewing the abortion as a punishment was an intriguing interpretation of events and it is possible that some women could perceive abortion as a form of punishment.

In contrast to the above example, another participant spoke in more positive terms of a medical abortion allowing women to gain control:

‘but people that I’ve spoken to afterwards that have had medical termination said they have had ownership, they have had the power, they have been able to, they have been in control, with the surgical they have been out of control it has been taken out of their hands so when people have said they have had a surgical and then had a medical erm, that its, that they felt more in control, they were more aware of what is going on and that the after effects were less than when they had the surgical (Interview 1).

This participant was alone in this study in feeling that some women gained control through having a medical abortion.
Surgical termination was still favoured by a number of participants who felt that, although there was an anaesthetic risk, it was a relatively minor procedure in which the woman has little involvement and thus trauma. Ward participants spoke of the consequences of having more hands-on involvement with medical terminations as well as the repercussions on the woman. There was recognition that the emotional side of care demanded a lot more of them as those closest to the women during the process.

‘They’d come in for a surgical procedure, you’d prepare them for theatre, you’d take them to theatre, you’d care for them post-op and they’d go home. … it was still there, but the emphasis wasn’t on the emotional side. And of course when we changed to medical abortions we were all thinking at the time ‘oh, my gosh’, putting patients through that sounded horrendous. Ignorance I suppose and not familiar with it, but once we started managing them medically I think that’s when it really hit home how emotional the procedure was’ (Interview 8).

‘I think that a SToP, although you’ve got a risk from the anaesthetic I mean it’s much easier from their point of view, they go to sleep, they wake up and it’s done and they are with us’ (Interview 4).

It is clear that surgical termination allows nurses and women to view surgical abortion as a minor procedure whereas medical termination with the existent foetus makes the pregnancy loss a reality resulting in an emotional experience for the woman and the nurse involved as can be seen in the data below.

‘Having given them the tablets, …they see the bleeding, they see the products, because they go to the toilet and … some people look and they are so upset because it’s a perfectly formed little baby and they don’t expect it to be like that’ (Interview 4).

The nurses appreciate the toll that this process took on the women, but only a few spoke of the emotional burden for them.

‘It does upset me sometimes when I see them and you know? The student nurses keep saying I don’t know how you can do this every day and I think if you are in it every day you have got to obliterate it from your mind really, not just think about what you are actually doing sometimes’ (Interview 3).

**Fostering a woman-centred service**

This was the central phenomenon of the grounded theory. In many of the services represented by the participants, nurses were at the forefront of service provision. However, it seems that rather
than nurse-led services being a goal, the participants strived towards a woman-centred service. This was evident in the participants placing women as central in their own decision-making. This strategy was adhered to even when it would have been expedient for the nurse to ‘coax’ the woman into making her decision

*I just deal with my ladies on a personal basis, on a one to one and as an individual and just treat everybody differently due to their circumstances and do the best I can for them erm, because everybody has a different sort of scenario and problem’ (Interview 5).

In a socio-economically deprived area this nurse is in tune with the needs of the women using the service and has adapted it to be as woman-centred as possible

*We try to limit the amount of visits to the service because of social problems, work commitments, travel commitments and also, being such a confidential service a lot of women have to keep this confidential from their home as well. We actually admit on a Sunday ...but we were finding ...a lot of the women were declining the Sunday admission even though the facilities were better and the privacy was better I think basically there were problems with explaining to their relatives why they were missing on a Sunday’ (Interview 5).

The data above reveal nurses putting the needs of the women first at a vulnerable time in their lives.

**Discussion**

The initial part of the discussion gives an insight into the first aim of the study of how the nurses perceive their role. This is focused on facilitating a woman’s decision on whether to undergo an abortion within a specific context. The latter part of the discussion illuminates the second aim of establishing how nurses cope with the role of supporting women undergoing medical termination.

The goal to provide comprehensive information in a neutral manner was an overriding theme in the data and contributed towards the ability of the women to make their own choices with their contextual constraints. The participants were keen to stress that the woman’s decision was a profound one and that their neutrality in encouraging the right decision was essential. A study which explored women's experience of referral for abortion in three inner London boroughs sought to determine if services met their expectations (Kumar et al., 2004). The authors found, during in-depth interviews that because most women had made a decision to proceed with
abortion before approaching the health service, they preferred not to discuss their decision but expected information and prompt referral.

Gestation was a major time constraint on decision-making as it affected the type of abortion, the location of the procedure and even the feasibility of an abortion. The participants were mindful of ensuring that all the options were given to the woman contingent on the gestation of the foetus. In a US study of factors hindering access to abortion services, gestation limits played a major part (Henshaw, 1995). Like Henshaw (1995), other contextual constraints emanated from the location of the termination of pregnancy service as some trusts offered medical termination of pregnancy only or contracted their services out of Wales to England. The gestation limit differed in each trust, and even between hospitals within trusts, which influenced advice and options that could be given by the participants.

Sherwin (1989) proposes that contextualising a problem results in a solution which is possible within the woman’s circumstances. This view echoes the data where the participants were acutely aware of how life can change so rapidly. The decision for an abortion had been made in the ‘here and now’ by the women and the nurses seemed to sense this and became unwilling to influence the decision in any way. The ‘here’ relates to the woman’s individual context which the nurses were at pains to explore in order to provide individualised care, whereas the ‘now’ relates to the time constraints which were present when making a decision whether to abort and if so, by which method.

Dealing with a woman undergoing abortion demands great skill and sensitivity often within a constrained period with the nurse circumnavigating embarrassment and vulnerability to ensure that the woman has made the right decision. This situation tested the nurses’ ability to form meaningful relationships. Relationships are often described as a web (Alderson, 1991; Gilligan, 1982). This provides a graphic representation of the situation where the nurse is liaising with several colleagues, the woman and possibly a partner or friend to ensure that information is communicated accurately, appropriately and sensitively within a limited time scale. Another dimension to the web is that not all relationships are equal (Sherwin, 1989). The women attending were in a fragile state that made them vulnerable to exploitation in relationships. As in
the above example, inherently the participants seemed to recognise the inequity in the circumstances and try to reverse it by giving the women choice and space within the confines of the context.

Viewing the abortion as a punishment was an intriguing interpretation of events by one participant. Given the possibility that some women could perceive abortion as a form of punishment, it is vital that the nurses and midwives involved manage the care to deflect this perception by acting in a non-judgemental manner (Koh, 1999). Another participant was alone in feeling that some women gained control through having a medical abortion. However a US study qualitatively analysed women’s experiences of this procedure and found that women who chose their method wanted to maintain control of the process (S. L. Fielding et al., 2002).

The following latter part of the discussion illuminates the second aim of establishing how nurses cope with the role of supporting women undergoing medical termination. The term ‘obliterate’ was used by one participant and others used similar phrases to describe how they overcame the emotional burden of termination. Froggatt (1998) cites three ways in which the emotions can be contained; ‘shutting off’ – removing access to the emotions, ‘hardening’ – raising a barrier to the emotions and ‘stepping back’ – being mentally distanced from the emotions. It is evident from the example in Interview 3 that during their initial experiences the participant could not readily contain her emotions, but that by ‘shutting them off’ she had learned to do so over time. The data nevertheless were replete with examples of compassion, dedication and justice for the women for whom they cared signifying that their concerns had been channelled into productive outcomes. Bolton’s study of offering emotion work as a gift to women found that dealing with the women’s grief was emotionally intensive for the nurses, but that none of them regretted imparting the gift (Bolton, 2000).

Women considering an abortion are generally not viewed favourably by society (Eposito & Basow, 1995) or by some health care professionals (Ventura, 1999; Webb, 1984). Women also judge themselves harshly when in need of an abortion (Weidner & Griffitt, 1984). O’Grady (2005) explores women’s relationship with themselves and finds that it is often women’s relationship with others which defines them. This in turn subordinates them and their own needs
and goals. Women also perform what O’Grady (2005) terms ‘self-policing’ involving self-criticism leading to self-doubt. Against this backdrop of disempowerment and vulnerability, the participants in this study were able to support and empower the women to make their own decisions by providing a woman-centred service.

Much of the qualitative research on abortion care has shown the emotional commitment necessary for those caring for women undergoing abortion (Bolton, 2000; McCreight, 2005; McQueen, 1997) Their findings have been echoed in this research with most participants recognizing the emotional impact of medical abortion on the women and a few acknowledging their own burden. Providing a remedy for this emotional intensity would not be easy in the high-pressured environment of acute gynaecology services. Moving abortion care into a less pressured environment such as primary care may be an option as long as it fulfils statutory obligations for the procedure. Formal support for those involved such as guided reflection (Johns & Freshwater, 1998) would highlight this issue at level of service provision and may help those involved to articulate and work through the emotions evoked by such intense involvement.

The majority of quantitative research shows a degree of animosity towards the service from barriers to access in Australia (Calcutt, 2007) and France (Decerf et al., 2000) and harassment in 45% of the 163 hospitals studied in Ferris’ Canadian study (Ferris et al., 1998) to violence and deaths in the USA cited by Ventura (1999). Although no specific examples of harassment were evident in these data there was an appreciation of the sensitivities surrounding the service by the participants. Within these constraints, good practice and expertise needs to be shared to ensure optimum care. For example, the all-Wales (UK) Termination of Pregnancy Network meets regularly as a professional development and reflective practice forum in the area where this research was undertaken.

This research has shown that despite the contentious nature of the topic that those participating in this study maintained a facilitative approach to their work, which enabled the women to be at the forefront of the service at a time when they were at their most vulnerable.
Conclusion

This study was performed in the light of recent and impending developments in ToP. It sought to determine the major affective attributes of nurses/midwives caring for women undergoing ToP. All but one of the participants stated that being non-judgemental was crucial. However, the participants conceded that they were judgemental, but concealed their judgements from the women. A major issue, which gave rise to them being judgemental, was repeat ToPs. This was counteracted by using maxims, which enabled the participants to conceal their judgements in order to deliver care. Goffman’s work on stigma was applied in exploring some of the explanations for the findings. Based on this research it is worth asking whether wholly non-judgemental care is a realistic expectation. If it were not then perhaps a more honest approach would be to concede and then appropriately conceal any judgements made in a reflexive approach to care.

A grounded theory of fostering a woman-centred service was developed through the process developed by Strauss and Corbin (1998). The participants used their expertise to guide the women through the process so that they made the appropriate choice of whether to have an abortion. Nurses and midwives took the woman’s individual circumstances into account and recognised that it must always be the woman’s decision. It became clear that some participants had reservations about the move towards medical terminations as it highlighted the emotional impact of the procedure for the woman as well as the nurse or midwife.

An aim of feminist grounded theory is to make a difference to the lives of those it studies. In acknowledging the complexity of the task of caring for women undergoing termination of pregnancy for nurses/midwives this research has initiated the debate on how such care can be facilitated in a woman-centred environment.

References
See end of document.
Figure 1 Paradigm model

Causal conditions
- Personal experiences
- Gynae career
- Woman’s decision for ToP
- MToP, SToP, Miscarriage

Consequences
- Justification of ToP
- Investment of self
- A worthwhile service

Phenomena

ToP expertise

Personal values and mores

Conceding and concealing judgements

ToP continuum

Intervening conditions
- Advancing technology
- Interpretation of legislation
- Conscientious objection
- Existent foetus
- Appreciating context
- Reason for ToP
- Woman’s response to ToP
- Repeat ToP
- Repeat ToP

Strategic inter/actions
- Offering advice
- Offering options
- Equitable care
- Coping mechanisms
- Use of maxims
- Fostering woman-centred care

Fostering an authentic service
Table 1 Conditional matrix
The conditional matrix is an analytic aid proposed by Strauss and Corbin (1990) to consider how the various kinds of conditions (causal, contextual and intervening) influence the actions and result in the consequences of the phenomena. The purpose of the matrix is to form an explanatory framework for a number of levels from international to individual. Strauss and Corbin (1990) assert that the conditional matrix increases theoretical sensitivity to arrange of conditions which influence the phenomena as well as enabling systematic association between them and the actions and interactions and their consequences.

<table>
<thead>
<tr>
<th>Level</th>
<th>Interpretation in ToP services</th>
</tr>
</thead>
<tbody>
<tr>
<td>International</td>
<td>ToP is viewed differently in other countries. Some take a more liberal view than the UK and other countries do not accept ToP as a legally or morally acceptable procedure. The repercussions of political decisions made in dominant countries such as the USA can often be felt in the UK. The international perspective has implications for the UK as many non-UK nurses and medical staff work in gynaecology.</td>
</tr>
<tr>
<td>National</td>
<td>The national perspective is bound by English law and the 1968 Abortion Act (revised in 1990) where abortion is only legal is very specific circumstances. The law is sometimes interpreted liberally by those working in ToP. For example, ‘the risk of more harm occurring to the woman in continuing the pregnancy’ is interpreted as a reality with a higher risk of DVT. The term ‘social termination’ was used by some participants even though this is not a legal entity.</td>
</tr>
<tr>
<td>Community</td>
<td>This differs depending upon local issues such as the dominant religion, whether a region is rural, suburban, and cosmopolitan. This will affect whether a ToP service will be deemed acceptable in a certain community.</td>
</tr>
<tr>
<td>Organisation</td>
<td>Each Trust in Wales organises its ToP services differently with some being based in secondary care and others in primary care. Some are medically driven and others are nurse/midwife-led.</td>
</tr>
<tr>
<td>Directorate</td>
<td>The directorate with specific responsibility for ToP services is regulated by specific procedures and protocols. This will influence how many ToPs are performed in each week, which type (MToP, SToP) and the location (day surgery, outpatients, gynaecology ward).</td>
</tr>
<tr>
<td>Team action and interaction</td>
<td>The ToP team may comprise counsellors, nurses, midwives and doctors. All members of a team may be involved fully or partly with ToP patients. In other teams designated team members may be allocated for ToP care. Some team members may conscientiously object to being involved with ToP which can impact on the service.</td>
</tr>
<tr>
<td>Axial codes</td>
<td>Open codes</td>
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<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Conceding, concealing judgements</td>
<td>Judging</td>
</tr>
<tr>
<td></td>
<td>Being non-judgemental</td>
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<tr>
<td></td>
<td>Repeat ToPs</td>
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<tr>
<td></td>
<td>Use of maxims</td>
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<tr>
<td>Personal and professional investment of self</td>
<td>Continuity</td>
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<td></td>
<td>Displaying expertise</td>
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<td></td>
<td>Displaying attributes</td>
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<td></td>
<td>Gynaec career</td>
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<td>Offering advice</td>
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<td></td>
<td>Offering options</td>
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<td></td>
<td>Role satisfaction</td>
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<tr>
<td></td>
<td>Conscientious objection</td>
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<tr>
<td></td>
<td>Interpretation of legislation</td>
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<tr>
<td></td>
<td>Participant’s background</td>
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<td>Coping mechanisms</td>
</tr>
<tr>
<td>Justifying ToP</td>
<td>Doing what is right</td>
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<td></td>
<td>Justifying working in ToP</td>
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<td>Worthwhile service</td>
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<td></td>
<td>Contextual constraints on decision making</td>
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<td>Woman’s response to ToP</td>
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<td></td>
<td>Equitable care</td>
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<tr>
<td>ToP continuum</td>
<td>Changes in ToP care</td>
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<tr>
<td></td>
<td>SToP, MToP, miscarriage</td>
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<td></td>
<td>Gestation</td>
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### Table 3 Inter-axial coding

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Phenomena</td>
<td>Personal and professional investment of self</td>
</tr>
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<td></td>
<td>Conceding and concealing judgement</td>
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<tr>
<td></td>
<td>ToP continuum</td>
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<tr>
<td></td>
<td>Fostering a woman-centred service</td>
</tr>
<tr>
<td>Causal condition</td>
<td>Personal experiences</td>
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<tr>
<td></td>
<td>Career in gynaecology</td>
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<tr>
<td></td>
<td>Woman’s decision for ToP</td>
</tr>
<tr>
<td></td>
<td>MToP, SToP, miscarriage</td>
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<tr>
<td>Context</td>
<td>Caring at specific point on ToP pathway</td>
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<tr>
<td></td>
<td>ToP procedure</td>
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<tr>
<td></td>
<td>Current position</td>
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<td></td>
<td>Legislation</td>
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<tr>
<td>Intervening conditions</td>
<td>Advances in practice</td>
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<tr>
<td></td>
<td>Interpretation of legislation</td>
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<td></td>
<td>Conscientious objection</td>
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<td>Existent foetus</td>
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<td></td>
<td>Appreciating the context</td>
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<tr>
<td></td>
<td>Reason for ToP</td>
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<td></td>
<td>Woman’s response to ToP</td>
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<td></td>
<td>Repeat ToP</td>
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<tr>
<td></td>
<td>Perceived lack of counselling skills</td>
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<tr>
<td></td>
<td>ToP knowledge</td>
</tr>
<tr>
<td>Action/interaction strategies</td>
<td>Offering advice - (personal and professional)</td>
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<tr>
<td></td>
<td>Offering options - investment of self</td>
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<td></td>
<td>Equitable care</td>
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<td></td>
<td>Coping mechanisms</td>
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<td></td>
<td>Use of maxims</td>
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<td></td>
<td>Caring for women on ToP</td>
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<tr>
<td></td>
<td>Continuum</td>
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<tr>
<td></td>
<td>Displaying attributes</td>
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<tr>
<td>Consequences</td>
<td>Justification of ToP</td>
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<td></td>
<td>Role satisfaction</td>
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<tr>
<td></td>
<td>Providing a worthwhile service</td>
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<tr>
<td></td>
<td>Concealing judgements</td>
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### Table 4 Intra-Axial code – Conceding, concealing judgements

<table>
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</thead>
<tbody>
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<tr>
<td>Causal condition</td>
<td>Woman’s decision for ToP</td>
</tr>
<tr>
<td>Context</td>
<td>Procedure of ToP: Assessment Admission Procedure</td>
</tr>
<tr>
<td>Intervening conditions</td>
<td>Reason for ToP Repeat ToP Woman’s response to ToP</td>
</tr>
<tr>
<td>Action/interaction strategies</td>
<td>Displaying attributes Coping mechanisms Use of maxims ‘There but for the grace of God’ ‘Do as you would be done by’</td>
</tr>
<tr>
<td>Consequences</td>
<td>Concealing judgements</td>
</tr>
</tbody>
</table>

### Intra-Axial code – Personal and professional investment of self

<table>
<thead>
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<th>Paradigm model</th>
<th>Codes</th>
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<tbody>
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<td><strong>Personal and professional investment of self</strong></td>
</tr>
<tr>
<td>Causal condition</td>
<td>Career in gynaecology</td>
</tr>
<tr>
<td>Context</td>
<td>Caring for women at a specific point on ToP pathway</td>
</tr>
<tr>
<td>Intervening conditions</td>
<td>Perceived lack of counselling skills ToP knowledge Life experience</td>
</tr>
<tr>
<td>Action/interaction strategies</td>
<td>Offering advice, offering options</td>
</tr>
<tr>
<td>Consequences</td>
<td>Role satisfaction</td>
</tr>
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</table>

### Intra-Axial code - Fostering a woman-centred service

<table>
<thead>
<tr>
<th>Paradigm model</th>
<th>Codes</th>
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<tbody>
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</tr>
<tr>
<td>Causal condition</td>
<td>Personal experiences</td>
</tr>
<tr>
<td>Context</td>
<td>Current position</td>
</tr>
<tr>
<td>Intervening conditions</td>
<td>ToP knowledge Existent foetus</td>
</tr>
<tr>
<td>Action/interaction strategies</td>
<td>Equitable care</td>
</tr>
<tr>
<td>Consequences</td>
<td>Justification of ToP role</td>
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</table>
### Intra-Axial code - ToP continuum

<table>
<thead>
<tr>
<th>Paradigm model</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenomenon</td>
<td>ToP continuum</td>
</tr>
<tr>
<td>Causal condition</td>
<td>MToP, SToP, Miscarriage</td>
</tr>
<tr>
<td>Context</td>
<td>Legislation</td>
</tr>
<tr>
<td>Intervening conditions</td>
<td>Advances in practice</td>
</tr>
<tr>
<td></td>
<td>Conscientious objection by colleagues</td>
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<tr>
<td></td>
<td>Interpretation of legislation</td>
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<tr>
<td></td>
<td>Existent foetus</td>
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<tr>
<td></td>
<td>Context constrained decisions</td>
</tr>
<tr>
<td>Action/interaction strategies</td>
<td>Caring for women on ToP continuum</td>
</tr>
<tr>
<td>Consequences</td>
<td>Providing a worthwhile service</td>
</tr>
</tbody>
</table>
Phase Three

Phase Three is a grounded theory study extending the findings of Phase Two by theoretical sampling. It has been prepared as an article which, following refinement, will be submitted for publication.
Introduction

A limited amount is known about nurses or midwives who deal with women undergoing abortion. Much of the research is centred on staff attitudes and this varies depending on the origin of the study, the designation of staff and whether they are working in the field (Lipp, 2008). Possessing the right affective attributes is essential in nurses/midwives involved in abortion care, but to date no research had been undertaken to explore this specifically. The small number of studies which have explored staff views on abortion, and more recently emotional investment in abortion care, are presented below.

Literature review

A Swedish study examined the views of 216 midwives and 228 gynaecologists and found that they overwhelmingly agreed legal abortion should be allowed (Hammarstedt et al., 2005). The respondents thought it should be the woman’s choice alone, but should not be a form of contraception. One third of the sample were not working with those undergoing abortion and they were more restrictive in their views than those who were. Interestingly, it is often argued that sound knowledge and access to contraception will reduce the abortion rate, but this study ascertained the numbers of participants who had experienced an abortion personally reflected the average rate in Sweden.

The aim of a US study covering six Californian hospitals and 75 labour and delivery registered nurses was to identify the frequency of nurse refusal to care for abortion patients (Marek, 2004). It found that nurses were more willing to care for abortion patients because of foetal demise or anomalies incompatible with life whereas few nurses would agree to care for women undergoing termination for sex selection or personal reasons. It is worth noting that 23% had received negative comments from their co-workers, some when they cared for the women and some when they refused.

A small US study by Kade et al (2004) points to abortion services being unavailable because of nurses’ unwillingness to participate. Caution is necessary in interpreting these findings because of the study size (17 physicians and three nurse managers) and debatable quality. McKee and Adams (1994) in their US study surveyed 1,208 nurse-midwives to determine their attitudes
towards performing abortion and related procedures. They found that supporters of abortion were more likely to have performed abortion-related services.

In South Africa, abortion was legalised in 1997 creating a sudden impact on the health delivery system as large numbers of women seeking abortions were met with a service ill-prepared to cope with demand (Poggenpoel et al., 1998). A groundbreaking programme of research to explore nurses’ experience of caring for women experiencing abortion was undertaken shortly afterwards (Poggenpoel et al., 1998). They found five major themes arose from the experience of nurses including the need for freedom of choice for nurses to provide support before, during and after abortion and turmoil in the nurses regarding life versus death. The research led to the production of guidelines to support nurses in this field.

In a 1994 study of nurses in various settings it was found that very few had extremely positive or negative views (Marshall et al., 1994). The factors associated with negative attitudes towards abortion included frequency of involvement, length of time spent working on a gynaecology ward, religious affiliation and ethnicity.

The following two studies are mostly closely linked to the topic of this research. A recent study was prompted as a result of a lack of recognition of moral distress caused to nurses undertaking abortion care (Hanna, 2005). Hanna (2005) used a modified phenomenological approach to identify the lived experience of participating in legal, surgical induced abortions in 10 nurses. Hanna (2005) found three ways in which nurses handled their moral distress in abortion care. Firstly, ‘shocked’ distress where they sought out others to listen to their stories secondly, ‘muted’ distress where they worked through their issues via conscious reflexivity and lastly ‘suppressed’ distress where their moral distress became internalised but not resolved.

Wolkomir and Powers (2007) studied nurses’ emotional labour in a US abortion clinic. They found the biggest challenge for nurses and the crux of emotional labour was balancing the needs of oneself with the needs of the job (Wolkomir & Powers, 2007). For example, emotional labour in abortion care sometimes requires the nurse to act in a way that is not in accord with her own values. The authors showed that nurses constructed three strategies to enable them to invest
emotionally in the best way for the patient allowing them to invest or detach appropriately (Wolkomir & Powers, 2007).

This current research was undertaken as a form of theoretical sampling based on the findings of a previous study by the same author undertaken into nurses’ and midwives’ affective attributes in abortion care. In the previous study the central phenomenon of the paradigm model emerged as ‘conceding and concealing judgements’. This relates to the finding that the nurses and midwives initially asserted that a major affective attribute was being non-judgemental in their care giving. During constant comparative data analysis, it became clear that being non-judgmental was an aspiration that was never attained. Once the participants conceded this, they explained how they concealed their judgements from the women for whom they cared.

**Study aim**
The aim of this follow up study is to explore how nurses cope with conceding and concealing their judgments towards women having an abortion.

**Method**
Grounded theory underpinned the study using a recognised approach (Strauss & Corbin, 1990). It was chosen above other methods as it focuses at the level of human action and interaction as well as being structured, systematic and simultaneously flexible (Gerrish & Lacey, 2006). Main sources of data were associated literature, the author’s previous clinical experience and semi-structured interviews. Interviews were chosen as they offer ‘a practical, flexible and relatively economical way of gathering research data’ (Bowling & Ebrahim, 2005: 217).

Grounded theory has four major tenets which characterise it (Ball, 2001). These are theoretical sensitivity, theoretical sampling, constant comparative analysis and theoretical saturation.

Firstly, theoretical sensitivity concerns the researcher’s personal philosophy and interpretation of the data. One source of theoretical sensitivity is professional experience. In the previous study, I had developed knowledge of abortion care and expertise in grounded theory which allowed me develop a theory that is grounded and well integrated. Another source is the literature. There is debate within grounded theory as to whether the literature should be accessed before embarking
on research using this method (Charmaz, 2006; Polit & Beck, 2006). As a researcher I believe that it would be irresponsible to enter the field without prior understandings and knowledge of the relevant literature (Heath, 2006). Remaining cognisant of this standpoint, the literature around the role of nurses in abortion is limited and accessing it helped to ensure that the proposed study did not explore a previously researched area.

Secondly, theoretical sampling was used as a basis for this study. It is described as ‘sampling on the basis of concepts that have proven theoretical relevance to the evolving theory’ (Strauss & Corbin, 1990: 176). This follow up study was designed via theoretical sampling to develop concepts which were present and of proven theoretical relevance in the initial study.

Thirdly, constant comparative analysis refers to how data were analysed and contrasted as they were collected. This helped to shape the later interviews, gain a deeper understanding of phenomena and led to the need for theoretical sampling. Lastly, theoretical saturation is the ultimate aim of grounded theory. By the end of this study no new categories emerged related to the core category although saturation can be an elusive concept and it is difficult to state categorically that saturation was reached (Gerrish & Lacey, 2006).

Symbolic interactionism provided a philosophical approach, which enabled sense to be made of the complexities of the participant’s world. In symbolic interactionism the participants were able to give meaning to their behaviour and define their own situations through the research, the main premise being that theory emerges from, and is grounded in, the situation (Blumer, 1969).

**Rigour**

For the results to be trustworthy, research has to demonstrate its credibility. In the qualitative paradigm parameters of credibility include generalisability, validity and reliability.

It is frequently argued that qualitative research does not aim to be generalisable. However, theory developed in one study may provide an explanation for the experiences of others in a similar situation (Horsburgh, 2002). The terms fittingness and applicability are suggested as more appropriate than generalisability in qualitative research (Appleton, 1995). As sufficient
contextual information is provided in this study, it is possible that nurses in similar areas of care will recognise the challenge of conceding and concealing their judgements (Koch, 2006).

Clarke (1995) claims that qualitative researchers are preoccupied if not obsessed with reliability and he recounts the demands this places on qualitative research. Generalisability or applicability, as mentioned above, is associated with external validity. Whereas internal validity is related to measuring what it was intended to measure (Sandelowski, 1986). The term credibility is often used to capture internal validity and is deemed present if the data reveal accurate descriptions of individual’s experiences (Appleton, 1995). In this study, the participant’s comments are quoted verbatim and the transcription and interpretation was checked with them before publication.

Cutcliffe and McKenna (2004) advocate the use of audit trails in qualitative research to ensure the process is explicit and open to scrutiny, confirming credibility. According to them, this will ensure the findings arise from the data and not from ‘thin air’. To adhere to this principle, participants were consulted on the use and interpretation of their data and the data analysis was checked with a colleague for internal validity.

If a research study is to be of use to the clinical community then it must do more than describe a phenomenon, it must interpret, explain and attempt to solve problems in practice (Cutcliffe & McKenna, 2004). Cutcliffe and McKenna (2004) acknowledge that this is a challenge for grounded theory as when the conceptualisations become more complex external scrutiny becomes more demanding, if not impossible. This research aims to describe and interpret in order to stimulate clinicians to provide strategies for overcoming the problems in practice.

**Research governance**

Multiple Site Research Ethics Committee approval had been ascertained for the previous study. However, as specific concepts needed to be explored in more depth via theoretical sampling it was necessary to submit a notice of substantial amendment of the semi-structured interview sheet (Appendix 3) to the regulator of NHS research the National Research Ethics Service (NRES). Approval from the trust Research Governance Committee was also received prior to the initial and follow up study. Data gathered was stored securely according to NRES guidelines. All
participants were assured of their anonymity and pseudonyms have been used to identify data following interviews.

The setting
The study was conducted in one Welsh NHS trust with nurses based on a gynaecology unit in one district general hospital. In the unit only medical abortions were performed, women having surgical abortions were cared for in a separate part of the hospital. The unit comprised a ward and several clinics dealing with gynaecological issues such as abortion, continence and fertility, which were nurse-led by some of the participants.

The participants and sampling
As mentioned, the sample was expanded in response to the findings in the initial study via theoretical sampling. To ensure sampling relevance (Horsburgh, 2002) nurses experienced in abortion care in one specific trust comprised the sample for this study. This purposive sample met the criteria for grounded theory study as they were experts in the field of abortion care. There were five nurses with between 10 and 30 years experience. The relatively small number of participants was legitimate as this follow up study built on the findings from 12 nurses and midwives in the initial study.

To ensure confidentiality, all participants were identified by interview number. One participant had been interviewed in the previous study. One negative case comprised a participant who had strict religious beliefs, precluding her involvement in the administration of medical abortifacients. Otherwise, she participated fully in the nursing care of the patients.

Data collection and analysis
Interviews were performed over one month in the participant’s hospital, in a room near the ward where the nurses worked, to ensure minimal inconvenience. A semi-structured topic guide was used to stimulate discussion (Appendix 3 p 114).

The following section will illustrate that the aims of the study have been met. The data will be examined in relation to the context of lower gestation but greater nursing involvement, the
interactional strategies of conceding and concealing judgement as well as the intervening conditions of equitable treatment. All of these categories articulate with and support the phenomenon of self-preservation for the nurse and the woman (as viewed by the nurse) experiencing medical terminations of pregnancy. This will then be discussed in relation to its impact on nursing (Figure 2 p 87).

Findings
The context
All of the nurses had been in gynaecology and abortion care for a decade or more and had seen many changes including a reduction in gestation. This was viewed by the participants as an improvement in their job satisfaction as well as for the women

... ‘when I started working here it did used to bother me a lot more. After work you used to go home and be thinking about it. At the time we were dealing with terminations of a higher gestation than we do now and that used to upset me a little bit you know. I used to have nasty dreams about it you know?’ (Interview 1)

‘Well since we’ve gone to 12 weeks and under it’s a lot better I’ve got to say than up to 20 weeks we were years ago’ (Interview 2)

Gestation times for abortion are generally less now than a decade ago (DH, 2008). This has improved the working conditions for the nurses as one participant said

‘sometimes very early on you don’t see much’ (Interview 5)

However, a minority of abortions are still required at later gestations and are transferred to a tertiary centre for specialist care.

Unfortunately, the reduction in gestation, which has improved conditions is counteracted by the increased involvement required of the nurses caring for women undergoing medical abortion

‘But they expect to just pass a clot ... you know it depends what stage they are in their pregnancy ... it has its characteristics all it has to do is grow from 12 weeks onwards’ (Interview 5)
Although Interviewee 5 is expressing her concern for the woman, dealing with this type of situation on a regular basis takes its toll as seen in the testimony above by Interviewee 1 where she speaks of nasty dreams.

**Interactional strategies**

The strategies of conceding and concealing judgement were found in all but one of the participants in the previous study and all participants in this study, despite the initial declared aim of providing non-judgmental care. The example below shows how providing non-judgemental care is so ingrained that it is almost a mantra

> ‘they don’t know us (the nurses), they don’t know if we are going to judge them at all and we don’t judge them’ (Interview 1)

When probed on this, the reply reflects the turmoil the nurse faced when trying to be non-judgemental

> ‘everyone comes from different situations and backgrounds and we don’t really know them. We don’t know how they live. You do I suppose if you see people coming in for repeated terminations you obviously think about things, but I don’t think we ever show it, we don’t. I don’t think we judge them at all really’ (Interview 1)

The respondent seems unaware that implicit in her reply is a judgemental statement about women returning for repeat abortions.

The participant in Interview 4 shows the link between conceding and concealing judgement

> ‘Everyone’s got opinions but I think you should just keep them to yourself really when you are dealing with the woman. You have got to just think about what they are having done and how they feel at that particular point in time. Everybody has got a reason for coming in so we shouldn’t judge them for what ever that reason is’ (Interview 4)

**Intervening conditions**

The intervening condition of equitable care was drawn out of the challenges the nurses had in explaining that they treated women attending for abortion the ‘same’, but that sometimes they...
demanded a ‘different’ approach. This disturbed the participants as they tried to explain their individualised approach to care

‘I treat them all the same. I don’t treat one patient different from any other even though perhaps I feel sorry for one person more than the other maybe’ (Interview 5)

‘I think you do treat them differently because you’ve got some who are absolutely beside themselves … other women that are very practical about it, they want more information and you treat them differently again’ (Interview 3)

Both views are compatible with optimum care. By treating the women the same they did not discriminate or favour some over others as Interviewee 2 illustrates below. Equally, some women required a different approach depending on how they were coping with the procedure. These two seemingly conflicting interpretations of the situation are in fact compatible as they both involve providing equitable care.

The phenomenon
Self preservation as the phenomenon arises from the perspectives of both the nurses and the nurses’ views of the women. The nurses spoke of some women portraying a nonchalant attitude

‘Some are quite blasé and others come in and the are genuinely upset and you’ve just got to treat them all the same although deep down you have more empathy for certain ones’ (Interview 2)

‘It is upsetting when you nurse some of these ladies and they do seem very blasé about it you know?’ (Interview 3)

Mirroring the detachment from their situation that the women portrayed, the nurses also spoke of ‘switching off’ from their situation. One nurse used a telling phrase of ‘obliterating it’ (Interview 2).

Sara draws together the concept of self-preservation in the nurses and the women (according to the nurses) in the following remark
‘I think it’s something emotionally, you’ve got to try and switch off from. Some girls, ladies come in very blasé about it’ (Interview 1)

She speaks of switching off from the situation to enable her to cope and then immediately comments on some women being blasé in the situation. It was this remark that crystallised the connection between the nurses and women needing to protect themselves somehow within the situation. In the descriptions given by the nurses the manifestation of the self-preservation differed between the nurses and women. The nurses described the women expressing their unease with the situation (women being nonchalant) whilst the nurses seemed to suppress their unease.

**Discussion**

This section will expand on the findings in order and compare them with relevant literature and research. Emphasis will be on the central phenomenon of self-preservation with the intention of drawing out strategies for improvement in practice.

**The context**

Over the time the participants had been working on the ward trust policy had changed to limit terminations to under 13 weeks gestation. For those nurses who remembered the late gestation terminations, the reduction in gestation was a relief and enabled them to cope more readily. Dealing with terminations of 13 weeks and under locally is reflected in national demand as figures show a 33% increase in the number of abortions under 10 weeks between 2002 and 2007 (DH, 2008) with 90% of abortions now taking place under 13 weeks gestation.

This development has been paralleled by an increase in medical abortions accounting for 35% of the total in 2007, more than doubling in the last five years (DH, 2008). This has increased the contact that the participants have with the women as they take the woman through the process of ‘labour’ on the ward rather than caring for a woman undergoing minor surgery. Paradoxically although they were pleased to be able to deal with women undergoing abortions at a reduced gestation, the nurses were more closely involved in the procedure, which had repercussions for the phenomenon of preservation of self.
Interactional strategies – conceding and concealing judgement

Providing non-judgemental care is the aspiration of nurses, but whether this can ever be achieved is questioned by Hayter (1996). Koh (1999) uses a case study to highlight his argument that non-judgemental care is a professional obligation. Both papers use homosexuality to exemplify their case. Using such an axiomatic example provides stark evidence of the need for non-judgementality.

However, the data gathered in this research show that judgements are conceded and that they are then concealed.

In the data each participant includes a statement denying judgment. Initially the participants claimed not to judge the women but this modified to normative statements during the interviews (…‘we shouldn’t judge them’ (Interviewee 4)). The participants instead concealed their judgements, which they were more able to achieve.

Conceding judgement was a prominent issue that the participants struggled to reconcile by keeping their opinions to themselves. Having conceded that they judged the women, they then kept their own counsel affirming that this minimised the transmission of their judgements to the women. This ties in with Wolkomir and Powers’ study (2007) where nurses learned to take the stance of non-judgmental ally. It could be argued that this can only proceed once the nurse has conceded judgement.

Marshall et al (1994) found in their study that women do not always receive non-judgmental care when undergoing an abortion. Hanna (2005) found more recently in her phenomenological study on the moral distress of nurses in abortion care that the nurses’ personal values conflicted with their professional obligations which led in some cases to judgementalism. This conflict was further compounded by the lack of distinction made by nurses between judging the woman and judging the woman’s actions (Hanna, 2005). In the current study, some of the participants gave examples such as repeated terminations leading to the conclusion that it was the act of termination that was judged rather than the woman herself.

Intervening conditions
Providing equitable care was deemed an appropriate description for an apparent contradiction in terms. Some expressed the care they gave as being individualised depending upon the circumstances of the woman involved. Others were keen to stress the egalitarian nature of their care with no room for favouritism. However, both means of providing care met the aim of normalising the situation.

Younger (1995) uses the term alienation of the sufferer to describe why the nurses may have tried to deal with the women by treating them equitably. She proposes that suffering brings loneliness and alienation and that this in turn requires different approaches by the nurse in the form of caring. The participants in the current study stressed that the way in which they assisted them allowed the women to integrate into the environment thus lessening their alienation.

**The phenomenon – self-preservation**

The term self-preservation was chosen as the central phenomenon (Figure 1) as it befits the reactions of the nurses as well as the nurses’ descriptions of the women having an abortion. The phenomenon will be explored from both the nurses’ perspective and the woman’s position as described by the nurses.

Making an effort to preserve one’s self as a nurse dealing with abortion is understandable. The result of not being able to preserve ones’ self were described by Char and McDermott (1972) over 35 years ago. They were called upon as psychiatrists to study nurses in Hawaii six weeks after more liberal legislation on abortion was introduced. The study is not detailed with regard to sample size or method and thus the reliability of the findings are questionable. Nevertheless, it is one of the earliest acknowledgements that caring for women undergoing abortion may have a detrimental effect on nurses.

Other researchers of abortion care have found that being in the speciality can have detrimental effects on the nurse (Hanna, 2005; Marshall et al., 1994; Webb, 1984).

Instead of preservation of self, Wolkomir and Powers (2007) use the term authenticity of self to describe the need for congruence between one’s values and one’s behaviours. They argue that if
one does not act in accordance with one’s self-values it creates a sense of inauthenticity (Wolkomir & Powers, 2007). This theory can be applied to both the nurses and the women in this study. For example, one of the participants (the negative case) could not align her responsibilities with her religious beliefs, therefore creating a sense of inauthenticity. In this case it led to the nurse conscientiously objecting to being involved in administering abortifacient medication. It has been found that many women, undergoing an abortion have a conflict between their values and behaviours (Alex & Hammarstrom, 2004; Goodwin & Ogden, 2007; Wahlberg, 2007). Thus, the actions of the women undergoing abortion can also create a type of inauthenticity of self, manifesting itself in this current research as being blasé.

The phrases switching off and obliterating found in these data appear to correspond to suppressed distress found by Hanna (2005). Hanna established suppressed distress was unhealthy as it involved avoidance but that those with the greatest range of personal growth were those with muted moral distress. In muted moral distress nurses reflected quietly on their experiences to align their practice with their beliefs. Therefore encouraging nurses to reflect consciously on their abortion experiences is more likely to lead to convergence of personal values and professional obligations and is recommended for practice.

Coping is a way of preserving the self and various coping styles were evident in the data. A study examining a lifespan approach to coping showed that adolescents were distancing and confrontational whilst young adults used planned problem-solving and middle-aged and older people used escape-avoidance and self-blame more often (Irion & Blanchard-Fields, 1987). This could account for the blasé attitude of some young women described by the nurses. It could be argued that all of the women must have used planned problem-solving to a fair degree to organise attending for abortion. The responses of the older nurses were also congruent with Irion and Blanchard-Fields’ (1987) theory of escape-avoidance in using such phrases as ‘obliterating’ and ‘switching off’.

Folkman and Lazarus (1980) identified problem-focused and emotion-focused as two ways of coping. Problem-focused being where a problem is evaluated and if possible solved. This links to the women with an unwanted pregnancy seeking and obtaining an abortion. Emotion-focused
coping is less direct and involves regulating the emotional response to the problem. The nurses’ responses in trying to switch off and obliterate the event as a way of reducing the emotional impact shows emotion-focused coping. In addition, it indicates why the women were described as being blasé. Acting in a nonchalant manner could show avoidance and hide other emotion-focused coping strategies such as crying or expression of anger (Connor-Smith & Flaschbart, 2007).

A study of palliative care nurses, dealing with multiple bereavements, found that use of disengagement strategies was associated with greater emotional distress (Desbiens & Fillion, 2007). Although the nurses in this current study used terms associated with disengagement such as ‘switching off’ none of the nurses expressed any other signs of disengagement or indeed any current emotional distress.

Alienation of the sufferer (Younger, 1995) can also be applied to the phenomenon of self-preservation of the woman as the concepts of separation, shame and stigma highlighted by Younger (1995) fit well with procuring an abortion and the need to preserve one’s self. Firstly, the participants described abortion as a procedure that women have to undergo ultimately alone. Secondly, the participants acknowledged that abortion remains a shameful act with many women choosing not to disclose it even to close friends (Wahlberg, 2007). Lastly, a previous research study has shown abortion as epitomising stigma in its lack of acceptability by society (Major & Gramzow, 1999).

Emotional labour is a topic synonymous with care of women (Bolton, 2000; Bradshaw & Slade, 2003; McQueen, 1997; Smith, 1992). In Wolkomir and Powers’ grounded theory study (2007), they undertook interviews and participant-observation in a private abortion clinic in the ‘Deep South, Bible Belt’ of the USA. They found a very committed workforce who invested emotionally in their job. The staff in this study was found to divide their clients into three categories of ‘easy’, ‘hostile/ambivalent’ and ‘very hard’ (Wolkomir & Powers, 2007). The staff was able to invest heavily in the ‘easy’ clients as they were clear about the choice they had made and appreciative of the care given. The staff tended to detach selectively from the ‘hostile/ambivalent’ clients as they did not appreciate the staff’s services. The most challenging
client group for the staff were the ‘very hard’ clients as they were experiencing traumatic life events such as sexual abuse. The staff felt obliged to provide emotional labour, but were discerning about how they provided it. The authors found that by drawing boundaries around emotional labour, the participants were able to maintain their own integrity and avoid burnout (Wolkomir & Powers, 2007).

The discussion above has highlighted the literature associated with the categories drawn out of the data and compared it to this findings in this current study. The phenomenon of self-preservation is central as it demonstrates the way in which the nurses coped as well as indicating how some of the women attending for abortion may also manage their situation.

**Conclusion**

A previous grounded theory study sought to draw out the affective attributes of nurses involved in caring for women undergoing induced abortion and conceding and concealing judgements was found to be a central phenomenon. This current study involved theoretical sampling of five gynaecological nurses in one NHS trust all involved in caring for women undergoing abortion. The study met its aim to explore how nurses cope with conceding and concealing their judgments towards women having an abortion. It revealed that the nurses were able to cope by providing equitable treatment and then by switching off thus ensuring self-preservation. The need for self-preservation and the consequences of not preserving oneself were discussed from both the nurses’ and the women’s perspective.
Figure 2 Paradigm Model for Phase Three

**Cause**
Woman’s decision to abort

**Context**
Lower gestation
Greater nursing involvement

**Intervening conditions**
Equitable treatment

**Phenomenon**
Self preservation (Woman and nurse)

**Interactional strategies**
Nurses conceding and concealing judgement
Table 5 Axial Coding for Phase Three

<table>
<thead>
<tr>
<th>Causal conditions</th>
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<tbody>
<tr>
<td>Decision to abort</td>
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<tr>
<td>Influences and circumstances of the decision</td>
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<tr>
<td>Repeat abortion</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Context</th>
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<tbody>
<tr>
<td>Type of abortion (surgical/medical)</td>
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<tr>
<td>Gestation</td>
</tr>
<tr>
<td>Amount of nursing involvement</td>
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</table>

<table>
<thead>
<tr>
<th>Intervening conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women being blasé</td>
</tr>
<tr>
<td>Location of treatment (day surgery, gynae ward)</td>
</tr>
<tr>
<td>Others seeing with fresh eyes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action/interactional strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceding and concealing judgement</td>
</tr>
<tr>
<td>Treating women differently</td>
</tr>
<tr>
<td>Treating women the same</td>
</tr>
<tr>
<td>Going through the process with the woman</td>
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<table>
<thead>
<tr>
<th>Phenomenon</th>
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</thead>
<tbody>
<tr>
<td>Self-preservation</td>
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<tr>
<td>Nurse - switching off</td>
</tr>
<tr>
<td>Nurse’s view of the woman – blasé</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Consequences</th>
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<tbody>
<tr>
<td>Dreams</td>
</tr>
<tr>
<td>Being disturbed</td>
</tr>
</tbody>
</table>
Conclusion of the report

This report has been compiled as a summary of the research undertaken as part of the RCBC post-doctoral fellowship. The appendices following this conclusion give more detail on my professional development and the outcomes as a result of undertaking the RCBC fellowship.

Phase One

Undertaking Phase One has allowed me to influence policy at the level of the Welsh Assembly Government. It has also enabled sharing of information that was hitherto unknown at an all-Wales level.

Phase Two and Three

The findings from Phase Two have been profound, comprehensive and somewhat unexpected. During the analysis of Phase Two it became clear that Phase Three could not be structured as originally planned.

Phase Three was planned to be a questionnaire survey of all nurses/midwives caring for women undertaking ToP. There are three reasons why this was not chosen as the final phase. Firstly, the slow response to Phase One which required three reminders gave an indication that it was unlikely that if delivered to the lead nurse/midwife for each NHS trust in Wales that all questionnaires to all nurses/midwives would reach the target. Secondly, although different in each trust, the MToP and SToP services were often delivered in different trust settings, which also posed challenges to questionnaire distribution. Lastly and most importantly, the findings from Phase Two, although important did not lend themselves to quantitative measurement.

During the summer of 2007 when changing Phase Three became a likelihood I contacted experts in a number of areas to ask for their advice on ways forward. The experts included:

- RCBC community of scholars and the steering group
- Members of the management committee and steering group of RCBC
- My academic and peer mentor
- The two nurse consultant advisors
I decided that an extension to Phase Two in the form of theoretical sampling would help to consolidate my grounded theory and extend my skills in this research method.

These phases have created an impact on nursing practice within abortion care in Wales and beyond. This has been achieved through conference presentations (future presentations are also planned) as well as several publications.

Future research and studies that could arise out of this work include an evaluation of the all-Wales information leaflets and the integrated care pathway. An adapted version of the Phase One questionnaire could also be distributed on a regular basis to monitor the extent and quality of abortion services in Wales.

This project has been a tremendous opportunity, which has met all my expectations and more. I have grown personally and professionally through undertaking it.
RCBC Post doctoral fellowship professional development

Author’s background
In order to appreciate this research and its impact on my personal and professional development, a brief biography may be useful. I trained as a nurse in the Midlands from 1980 to 1983 and moved to South Wales shortly afterwards. I then worked in the operating department where I became clinically expert and later as a sister when I began to influence quality of care. I commenced as an unqualified nurse teacher in 1988 and began the long and rewarding navigation through my academic journey. En route, I gained a Diploma in Nursing with a distinction, a Certificate in Education, an MSc in Social Ethics at the University of Wales, Cardiff and subsequently an MSc in Social Science Research at the University of Glamorgan. These courses armed me with the confidence to teach on the subjects as well as explore them in more detail in the form of publications and conference presentations.

Later I went on to develop my PhD by portfolio based on clinical effectiveness. Clinical effectiveness had captured my imagination since its launch in Wales in 1996. It made so much sense and corresponded to my philosophy in health care. Basing my PhD on clinical effectiveness enabled me to demonstrate my contribution to its progress locally and nationally as well as allowing me to formulate new insights into its position in relation to evidence based practice and health care.

The RCBC post-doctoral fellowship has allowed me to apply the principles of clinical effectiveness to the specific topic area of termination of pregnancy both from a qualitative and quantitative perspective.
Developing expertise

It is important that the researcher is credible in the field of study to ensure that the research is performed appropriately and that the results will be plausible. Although I have a certain amount of research expertise, my knowledge of termination of pregnancy was limited to my experience in the operating department. Therefore, as part of undertaking the RCBC post-doctoral fellowship research I organised a development programme to increase my knowledge of this topic. This comprised contact with experts and visits in addition to a wide review of the literature.

Contact with experts

Two consultant nurses working in separate local NHS Trusts were the inspiration for this research and a meeting with them on an unrelated matter led to the idea that this research was necessary. The two consultants initiated an all-Wales Termination of Pregnancy network which would prove a useful lead into clinical practice. Throughout the research they have mentored me and provided clinical expertise on the project. They have given willingly of their time and expertise for which I am extremely grateful.

I had a very useful meeting with a newly appointed statistician in our Faculty. His advice at an early stage of the research led to a restructuring of the protocol and an improved rationale for the research.

I met several senior nurses and midwives involved in NHS ToP services locally. In doing so I had to be careful of not contaminating my all-Wales population.

As I was reviewing the literature I contacted authors for any relevant material associated with their work and electronic exchanges of information were rapid and may not otherwise have occurred. Many authors were extremely generous with their work and provided questionnaires, unpublished research studies and offers of further assistance.
I found that my previous projects and teaching responsibilities had provided me with a **wide range of experts** from members of local NHS Trust R&D committees to pharmacists to advise me on clinically specific aspects of the research. Therefore, during the course of this research I was able to access many experts who gave freely of their time and expertise.

**Teaching**

I have found when studying other topics that being able to teach others helped to consolidate my learning and this fellowship was no exception. I took every opportunity to teach students in our faculty on topics such as the research process I was undergoing as well as termination of pregnancy. This resulted in gaining new perspectives on my research as I was learning from gynaecological clinicians.

**Visits**

As University link teacher in a local **operating department** I attended several lists of surgical termination of pregnancies. Theatre staff were excluded from the research and so the visits were legitimate. It was also very useful as it allowed me to obtain technical information with regard to how the procedure is performed currently. The visits also allowed me insight into staff attitudes and because I knew the staff I could question them openly about their thoughts and feelings with regard to termination of pregnancy.

A visit to a **medical consultant in sexual health** was recommended by a colleague and proved useful as it gave me the opportunity to see how ToP is dealt with in one NHS Trust without contaminating the sample for my research. The consultant was knowledgeable and sympathetic to ToP as well as keen to improve staff development and support in this area.

The **British Pregnancy Advisory Service** invited me to see how their organisation works. As a national network it allows women to access abortion privately, although at the commencement of the research the Wales centre was limited to consultation and is awaiting inspection to be able to perform MToPs.
The Research Capacity Building Collaboration (RCBC) Wales conference was an ideal opportunity to increase my knowledge of termination of pregnancy and research methods. The conference was held at the commencement of my research and so I was able to refine my research based on comments to the paper I presented and as a result of advice from colleagues. For example, I met an RCBC doctoral fellow who ostensibly appeared to be undertaking very similar research to mine. Following detailed discussion at the conference and extensive email contact we managed to coordinate our individual projects so that they compliment each other rather than conflict.

I was invited to speak to the all-Wales Reproductive and Sexual Health Forum about my research and found their advice very pertinent and challenging. For example, they suggested focus groups as an alternative to individual interviews. The discrepancy in Wales about when nurses and when midwives may be involved in ToP was discussed. This was an important point, as I need to disentangle this to ensure that my research reaches all relevant staff. During the course of my research I was invited to become a member of the Forum and now attend and contribute on a regular basis.

A Marie Stopes Clinic in England invited me to see how the organisation operates. This was a very insightful day with the manager spending a great deal of time with me and giving her expertise freely. I was able to see the premises and appreciate how the women progress through the system. It was made clear by the manager that MSI does not always conform to what the Health Care Commission demands, but the rationale given to me were logical and acceptable. I was also advised to access their publications, which are available full text on-line.

Through my consultant nurse links, I was invited to the Royal Hallamshire Hospital in Sheffield. There I spent the day with the consultant nurse attached to the ToP service for Sheffield. This was a useful reminder of how differently the NHS functions in England with the community services there (PCTs) comprising a separate Trust to the acute hospital. This created an added challenge to streamlining services. The women have direct access to the ToP service and are counselled in the PCT and come into hospital for the procedure. There is a 60:40 ratio of MToP to SToP but this tends to be because of service demands rather than patient demand.
Around 20% of the gynaecological nurses volunteer to undertake ToP care and treatment. MToP procedure continues to be 48 hours between medications with the woman remaining in hospital to abort.

I attended several study events to augment my research knowledge including
- IT in research module 2006-7 (SPSS and NVivo)
- Ethics in Research CRC Cymru, Swansea, December 2006.
- Data Sanity, NLIAH, Swansea October 2007.
- Combining Research Methods, Swansea, December 2007.
- Story telling conference CIA Cardiff, January 2008
RCBC Community of Scholars

The bimonthly meetings of the community of scholars was a major attraction in applying for this fellowship. Research can be a solitary process and having colleagues undergoing similar process and available for advice and support became a strength of the fellowship. Electronic communication assisted this process, as for the most part we were geographically remote. The group comprised pre and post-doctoral fellows and whilst there was informal mentorship of the doctoral fellows by the post-doctoral fellows this relationship was often reciprocal as the post-doctoral fellows were challenged by seemingly naive questions.

Pitching the bimonthly meetings at the right level and ensuring that they covered relevant material for such a variety of projects and various stages was a formidable task, but one which with some fine-tuning and a consensual approach, the organisers successfully achieved.

The following were two of the most rewarding sessions on the community of scholars programme. The overnight meeting at Gregynog was very successful as it allowed time for informal gatherings and networking. The theme of leadership was also a valuable one for all the scholars. The most rewarding study day from a personal perspective was the media awareness training. It was taught by experts who gave constructively critical feedback. It had a good combination of theory and practical exercises, which kept us all alert throughout the day.

In addition to developing relationships with each other, we were also able to establish networks between fellows and colleagues from our own universities working in similar fields, which increased future potential liaison. Relationships built up over the two years will last much longer and I have no doubt that many of the scholars will become career-long colleagues and potential collaborators in future projects.

I have presented the findings of this post-doctoral fellowship at the final RCBC study session in September 2008 at Lechwyn Hall.
RCBC fellowship outcomes

- Membership of the all-Wales Reproductive and Sexual Health Group
- Observer with the all-Wales ToP Network

RCBC publications accepted or in print:


RCBC presentations:


**Dissemination of findings of Phase One:**

- Final report sent to all NHS trusts in Wales
- Presentation to the All-Wales ToP Network
- Discussion with Marion Lyons Sexual Health Lead WAG
- Presentation to the All-Wales Reproductive and Sexual Health Group
- One article accepted for publication
- Conference presentations

**Dissemination of findings of Phase Two:**

- Final report sent to all NHS trusts in Wales
- All-Wales ToP Network
- All-Wales Reproductive and Sexual Health Group
- Articles for publication
- Conference presentations
External funding as a result of the RCBC Post-Doctoral Fellowship

On completion of Phase One I requested a meeting with the all-Wales lead for sexual health. Among the findings was the variability in the quality of written information given to women in abortion services. Concurrent with this finding the all-Wales Network were developing an integrated care pathway for women undergoing abortion. As a direct result of the meeting and the findings from Phase One of the research £10,000 of funding was secured the Welsh Assembly Government to the all-Wales ToP nurses Network via the University of Glamorgan. The funding was allocated to provide an all-Wales integrated care pathway for termination of pregnancy as well as all-Wales leaflets on MToP and SToP and discharge advice (in Welsh and English). Provision of these leaflets will help to cement this research at an all-Wales level as well as disseminating evidence-based practice.

<table>
<thead>
<tr>
<th>Timescale</th>
<th>Task</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2007</td>
<td>Meeting WAG</td>
<td>Outlined Phase One, set up further meeting.</td>
</tr>
<tr>
<td>February 2008</td>
<td>Further meeting to discuss report details with relevant parties in WAG. First draft leaflets sent to Network for comments.</td>
<td>Secured funding £10,000 for production of leaflets and ICP.</td>
</tr>
<tr>
<td>March</td>
<td>Comments received from Network and incorporated into next draft.</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>Request to all trusts for logo, contact numbers, clinic times etc.</td>
<td>Most trusts responded with some information. Some trusts do not have new logo.</td>
</tr>
<tr>
<td>April</td>
<td>Subgroup meeting to discuss format of leaflets.</td>
<td>New draft developed.</td>
</tr>
<tr>
<td>May</td>
<td>Leaflets sent for Welsh translation.</td>
<td>All leaflets translated.</td>
</tr>
<tr>
<td>May</td>
<td>Translated leaflets sent for checking – a colleague and a</td>
<td>One minor error found.</td>
</tr>
<tr>
<td>Month</td>
<td>Event</td>
<td>Details</td>
</tr>
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<tr>
<td>May</td>
<td>Meeting of subgroup to discuss draft of ICP.</td>
<td>Next draft developed.</td>
</tr>
<tr>
<td>June</td>
<td>Revision of leaflets and formatting involving IT experts.</td>
<td>Produced Word documents and PDF.</td>
</tr>
<tr>
<td></td>
<td>A5 originally planned changed to A4 for printing and reproduction</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>Leaflets sent to all lead nurses/midwives in ToP Network for final comments.</td>
<td>One comment received from one trust which does not allow visitors during the procedure. Leaflet for this trust changed to accommodate this.</td>
</tr>
<tr>
<td>June</td>
<td>Final version sent to all trusts for piloting prior to next ToP network meeting at the end of July.</td>
<td>Negative comments from a consultant in a major trust restructure of leaflets.</td>
</tr>
<tr>
<td>July</td>
<td>Feedback taken at meeting</td>
<td>Decision to extend length of pilot.</td>
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<tr>
<td>October 2008</td>
<td>ToP network meeting item on agenda</td>
<td>Ongoing</td>
</tr>
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</table>
References


Appendix 1 Questionnaire Phase One

The Trust Questionnaire

The following questionnaire is designed to elicit information about services provided in your Trust for women undergoing termination of pregnancy.

**Policy information**

Please enclose with your response (Please tick the box if you have enclosed any documents)

<table>
<thead>
<tr>
<th>Any formal care pathway outlining termination of pregnancy</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any written information given to women during the initial consultation</td>
<td>□</td>
</tr>
<tr>
<td>Any written information given to women on discharge</td>
<td>□</td>
</tr>
<tr>
<td>Trust policy for disposal of foetal remains</td>
<td>□</td>
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</tbody>
</table>

List the major challenges to the termination of pregnancy service

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</tbody>
</table>

RCBC post-Doctoral Fellowship Final Report 107
**Information about your Trust**

1. Please state the number of Medical terminations of pregnancies (MToPs) performed in the Trust in 2005.  
2. Please state the number of Surgical terminations of pregnancies (SToPs) performed in the Trust in 2005.

3. Please state the number of consultants obstetricians and gynaecologists employed in the Trust.
   - Obstetrics
   - Gynaecology

4. How many of these consultants regularly perform ToP?  

5. Are doctors on rotational training involved in ToP? (If so, in what capacity?)
   - Yes  
   - No

   Please Specify:

6. Is there a Trust policy in place for staff who conscientiously object to being involved in the treatment of women undergoing ToP? If so, please enclose the policy.
   - Yes  
   - No

7. Please state the number of qualified nurses / midwives employed in the areas where women undergoing ToP are cared for (excluding staff whose only contact with the woman is in the operating theatre).
   - Primary Care
   - Secondary Care

8. Please state the number of qualified nurses / midwives normally directly involved with women undergoing ToP (excluding staff whose only contact with the woman is in the operating theatre).
   - Primary Care
   - Secondary Care
Information about the procedure

9. Please state how women are prioritised for ToP once in the system.
   - By Gestation
   - By method of ToP
   - In order from the date they are referred
   - Other (Please Specify Below)

10. Are there any constraints within the Trust which limit the number of ToPs performed?
    Tick all that apply:
    - Number of scan appointments
    - Number of theatre lists
    - Number of beds / slots
    - Other (Please Specify Below)

11. Please state if Trust arrangements are in place for:
    - Non-English speaking women
    - Women with special needs such as illiteracy
    - Assessment by a second doctor
    - Those who considered ToP, but do not proceed to abortion
    - Those who require additional support in decision making
    - Those under 16 years

Please enclose any Trust policies that apply to the above
12. Please state the customary time from initial referral to ToP?

- Up to 14 days
- 15 - 21 days
- 22 - 26 days
- 29 days and above

Q13. Please state the percentage of women care for as day cases in medical and surgical terminations.

Q14. Please state the time allocated to the initial consultation.

Q14b. Do you consider this to be:
- Adequate
- Inadequate
- Excessive

15. Please state whether the initial consultation takes place in a clinic dedicated to termination of pregnancy?

- Yes
- No

16. Please state whether women are able to choose between MToP and SToP? If they are not able to choose, what prevents this choice?

- Yes
- No

Q17. Please state the percentage of SToPs performed under:

- Local anaesthetic
- Conscious sedation anaesthetic
- General anaesthetic

Q18. For women accessing MToP, please state how many hours elapse between administration of the first dose of medication and administration of the second dose of medication?

---

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Q19. During the process of ToP are woman offered:
(if always, what is the uptake as a percentage)

<table>
<thead>
<tr>
<th>Test</th>
<th>Uptake (%)</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemoglobin level</td>
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<tr>
<td>Blood Grouping</td>
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<tr>
<td>Cross Matching</td>
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<tr>
<td>HIV Test</td>
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<tr>
<td>Hepatitis B &amp; C Test</td>
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<tr>
<td>Chest X-Ray</td>
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<tr>
<td>Cervical Smear Test</td>
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<tr>
<td>Vaginal Ultrasound scan</td>
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<tr>
<td>Abdominal Ultrasound Scan</td>
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<tr>
<td>Chlamydia Test</td>
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<tr>
<td>Histopathological examination of tissue</td>
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<tr>
<td>Anti-D immunoglobulin G (if appropriate)</td>
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<tr>
<td>Antibiotic prophylaxis</td>
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<tr>
<td>Routine prophylactic analgesia</td>
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<tr>
<td>PRN analgesia based on pain assessment</td>
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<tr>
<td>Sexual health advice</td>
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<tr>
<td>Healthy Eating advice</td>
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<tr>
<td>A 24-hour telephone helpline number for advice on symptoms they may experience</td>
<td></td>
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<tr>
<td>Written information on symptoms they may experience</td>
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<tr>
<td>A follow-up appointment (OPD - consultant, nurse)</td>
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<tr>
<td>Counseling</td>
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<tr>
<td>Contraceptive Advice</td>
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<td>Contraceptive Supplies</td>
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<td>Immediate Sterilisation</td>
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<tr>
<td>Other (Please State Below)</td>
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</tbody>
</table>
Q20. The following tables outline a variety of methods of performing termination of pregnancy.

Please state at what gestation and how frequently they are performed currently in your Trust.

**Medical Termination of Pregnancy**

<table>
<thead>
<tr>
<th>Method</th>
<th>Gestation (i.e. 7-12 weeks)</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mifepristone followed by gemeprost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>administered by nurse / midwife</td>
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<tr>
<td>Mifepristone followed by gemeprost</td>
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<tr>
<td>administered by the woman</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mifepristone followed by misoprostol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>administered by nurse / midwife</td>
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<tr>
<td>Mifepristone followed by misoprostol</td>
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<tr>
<td>administered by the woman</td>
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<tr>
<td>Medication administered vaginally</td>
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<tr>
<td>Medication administered orally</td>
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<tr>
<td>Other (Please Specify)</td>
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</table>

**Surgical Termination of Pregnancy**

<table>
<thead>
<tr>
<th>Method</th>
<th>Gestation (i.e. 7-12 weeks)</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
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</thead>
<tbody>
<tr>
<td>Manual vacuum aspiration under local anaesthetic</td>
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<tr>
<td>Manual vacuum aspiration under conscious sedation</td>
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</tr>
<tr>
<td>Manual vacuum aspiration under general anaesthetic</td>
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<tr>
<td>Electric suction aspiration under local anaesthetic</td>
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<tr>
<td>Electric suction aspiration under conscious sedation</td>
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<tr>
<td>Electric suction aspiration under general anaesthetic</td>
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<tr>
<td>Dilatation and evacuation (D &amp; E)</td>
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<tr>
<td>Other Regime (Please Specify)</td>
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Appendix 2 Phase Two topic guide

Title

An all-Wales examination of service provision for women undergoing termination of pregnancy and to identify and measure nurses’/midwives’ affective attributes who care for these women

To commence the interview and as an ice-breaker I will ask about the background of the participant.

The interview that follows will be open-ended and will be based on the following questions:

1. Could you share some of your experiences of being involved with the women undergoing termination of pregnancy?
2. What sort of characteristics do you think are necessary for the nurse/midwife to have in order to care for women undergoing this procedure?
3. Have you seen any changes in the way termination of pregnancy is carried out since you have been involved?
   a. If so, how have these changes affected you?
   b. A supplementary prompt will be used here regarding medical termination of pregnancy as appropriate.

The interview will build on the answers provided by the participant and will aim to be open-ended and non-directional.
Appendix 3 Phase Three topic guide

- Gloria is 14 years old, unsure about what to do. She has supportive parents.
- Louise is 19 years old, has two children and has had two previous abortions.
- Selma is 24 years old, a student in medical school and engaged to be married. She wants to begin her career before starting a family.
- Eileen is 29 years old, single and pregnant with an IUD in place.
- Margaret is 35 years old, divorced, pregnant from a one-night encounter, her first sexual experience following her divorce.
- Dorothy is 45 years old, married with three grown children. Neither she nor her husband wants any more children.

The above scenarios will be given to each participant on a separate sheet as a basis for discussion:

- A semi-structured interview will then follow based on the questions below:
  - What factors influenced your choice?
  - How did you feel making the choice?
  - What judgements came into play when making the choice?
  - How could you successfully conceal your judgements in practice?

The purpose of this exercise is to find out how the nurses/midwives manage their judgements of the women outlined. The case scenarios will anchor the semi-structured interviews, based on the questions above, and will comprise iterative cycles to clarify emerging concepts associated with the judgements they make. It is anticipated that the mechanisms for managing the tension between conceding and concealing judgements will also be drawn out during the interview.
## Appendix 4a Original timetable and milestones

### RCBC Post Doctoral Fellowship

<table>
<thead>
<tr>
<th>October 06</th>
<th>Novemb er 06</th>
<th>Decembe r 06</th>
<th>January 07</th>
<th>February 07</th>
<th>March 07</th>
<th>April 07</th>
<th>May 07</th>
<th>June 07</th>
<th>July 07</th>
<th>August 07</th>
<th>September 07</th>
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<td>Lit search</td>
<td>Lit search</td>
<td>Lit search</td>
<td>MREC approval</td>
<td>Trust R&amp;D process</td>
<td>Send out phase 1</td>
<td>Send out phase 2</td>
<td>Reminder Phase 1</td>
<td>Interviews phase 2</td>
<td>Analyse phase 2</td>
<td>Analyse phase 1</td>
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<tr>
<td>Questionnaire design</td>
<td>Ethics application</td>
<td>MREC and HESAS</td>
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<td>January 08</td>
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<td>Analyse phase 1</td>
<td>Write report phase 1</td>
<td>Write up Phase 2</td>
<td>Plan Phase 3</td>
<td>Write report phase 3</td>
<td>Write up Phase 3</td>
<td>Plan Phase 3</td>
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<tr>
<td>Write up Phase 2</td>
<td>MREC for phase 3</td>
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<td>Plan Phase 3</td>
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## Appendix 4b Current timetable for RCBC project

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<th>November 06</th>
<th>December 06</th>
<th>January 07</th>
<th>February 07</th>
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<th>May 07</th>
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<th>July 07</th>
<th>August 07</th>
<th>September 07</th>
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</thead>
<tbody>
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<td>Literature search</td>
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<td>Literature search</td>
<td>MREC approval</td>
<td>Send out phase 1</td>
<td>Reminder Phase 1</td>
<td>Reminder Phase 1</td>
<td>Reminder Phase 1</td>
<td>Analyse phase 1</td>
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<td>Questionnaire design</td>
<td>Ethics application MREC and HESAS</td>
<td>Refining article</td>
<td>Revision of ethics forms</td>
<td>Write NT article</td>
<td>Refining article</td>
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<td>Reminder Phase 1</td>
<td>Analyse Phase 2</td>
<td>Write up Phase 2</td>
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<td>Write article (attitudes)</td>
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<td>June 08</td>
<td>July 08</td>
<td>August 08</td>
<td>September 08</td>
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<td>Write draft report phase 1</td>
<td>Write report Phase 1</td>
<td>Refine report Phase 1</td>
<td>Refine report Phase 1 to lead N/M (confirmation)</td>
<td>MREC approval</td>
<td>Interviews Phase 3</td>
<td>Analyse Phase 3</td>
<td>Write up Phase 3</td>
<td>Writing article for publication Phase 3</td>
<td>Writing final report</td>
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<td>Write report Phase 1</td>
<td>Meeting WAG Phase 1</td>
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<td>Article Phase 2 (1)</td>
<td>Report Phase 1 to lead N/M (confirmation)</td>
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<tr>
<td>Plan Phase 3</td>
<td>Meeting WAG Phase 1</td>
<td>Article Phase 2 (2)</td>
<td>Article Phase 2 (2)</td>
<td>Article Phase 2 (3) Generic discussion articles (x2) Writing leaflets</td>
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<td>Draft final report</td>
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<td>Article Phase 2 x2</td>
<td>Article Phase 2 x2</td>
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<td>Translation of leaflets</td>
<td>Formatting of leaflets</td>
<td>Distributing leaflets to trusts</td>
<td>Piloting leaflets</td>
<td>Piloting leaflets</td>
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<td>Refining leaflets</td>
<td>Negotiating</td>
<td>Integrating back to</td>
<td>Teaching</td>
<td>Role</td>
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</table>
Appendix 5 Articles published

TERMINATION OF PREGNANCY

AUTHOR Allyson Lipp, PhD, MSc, MA, RN, RNT, is principal lecturer, faculty of health, sport and science, University of Glamorgan.


This article outlines both surgical and medical methods of termination of pregnancy, together with the legal circumstances in which termination can take place. As the number of medical terminations increases, nurses and midwives need to increase their knowledge and skills in this area.

Some 186,000 terminations are performed annually in England and Wales and about 11,500 in Scotland. The Abortion Act 1967 does not apply in Northern Ireland and no official statistics are collected there (Royal College of Obstetricians and Gynaecologists, 2004). At least one-third of British women will have had a termination by the time they reach the age of 45 years and one in five pregnancies results in termination (Lyons et al, 2000).

Access to terminations remains patchy. Although the NHS funds about 75% of terminations, there are significant differences between regions. Barriers to NHS provision include GPs’ reluctance to refer women and consultants’ unwillingness to perform terminations. The signatures of two doctors, acting in good faith, are required to certify that a pregnancy can be terminated (Alspop, 2004). Box 1 outlines the grounds for termination of pregnancy.

LEARNING OBJECTIVES

- Know the legal grounds for terminating a pregnancy
- Be aware of the preparations that women should undergo before having a termination
- Understand the different processes in surgical and medical terminations of pregnancy
- Be aware of the care nurses should provide to women following a termination

Before the procedure is undertaken all women must undergo a lengthy consultation that includes a physical assessment. Here they will be given a pregnancy test, if necessary, and will also be informed about the procedure and the complications both verbally and with additional, written information.

Written information based on national guidelines is recommended (Wong et al, 2008; RCOG, 2004). An ultrasound scan is normally performed in order to confirm gestation, although this is not a mandatory procedure. The absence of a gestational sac in the presence of a positive pregnancy test may indicate an ectopic pregnancy.

TERMINATION METHODS

There are two main types of termination. One is surgical termination of pregnancy (SToP), which comprises vacuum aspiration. The vacuum can be produced manually (MVA – manual vacuum aspiration) up to 10 weeks’ gestation. SotP is not suitable below seven weeks’ gestation (RCOG, 2004) but can be used up to 15 weeks (Alspop, 2004). It can be performed under conscious sedation, local or general anaesthetic. Most SotPs are performed as day surgery.

Medical termination of pregnancy (MTOP) involves the use of abortifacient drugs. MTOP is used between seven and nine weeks’ gestation and a different combination of medication can also be used for second-trimester terminations (Alspop, 2004).

MTOP is performed in two stages: first, the woman is generally prescribed mifeprisone orally in order to interrupt normal development of the pregnancy; she then returns about 48 hours later for the second stage, which involves administration of a prostaglandin analogue to initiate contractions of the uterus (Rorbye et al, 2005). It is important that the woman returns for completion of the treatment as the medication is thought to be teratogenic.
Sides-effects
Generally, the side-effects that occur with both types of termination include abdominal cramps, vaginal bleeding and diarrhoea. More specifically, MToP includes prostaglandin side-effects, such as headache, chills and fever. Following MToP, 5% of women are likely to require evacuation of retained products of conception, whereas 2% of women will require a repeat procedure after SToP.

The efficacy of both methods of termination is high. Short-term side-effects are more intense and last longer with MToP but there is a higher risk of infection with SToP that is thought to be associated with reduced future fertility — although evidence for this is weak. However, on this basis, MToP is recommended by a recent Health Technology Assessment as the optimal procedure (Forbye et al, 2005).

Choosing which method
Choosing between the methods available is known to be important to women regardless of the decision they make, and some facilities are able to offer women choice. Wong et al (2006) found that although there was no difference in the type of method chosen, women made more informed decisions when provided with an evidence-based leaflet before their consultation.

In the UK the percentage of MToP compared with SToP is rising, with 60% of terminations using MToP in Scotland.

REFERENCES


Forbye, C.L. et al. (2005) Medical Versus Surgical First Trimester: Abortion, Health Technology Assessment. Sundhedsstyrelsens; Danish Centre for Evaluation and Health Technology Assessment.

Wong, S.S. et al. (2006) A randomised controlled trial of a decision-aid leaflet to facilitate women's choice between pregnancy termination methods. BJOG; 113; 6, 688–694.

Registered nurses and midwives cannot refuse to participate in emergency care and treatment which may be associated with their conscientious objection (NMC, 2003). The NMC advises registrants to give careful consideration to working in an area of care to which they may object and to inform their manager of their objection at the earliest opportunity.

CONCLUSION
The skills that are required by nurses and midwives in termination of pregnancy are likely to increase as the number of MToPs rises, while there is also discussion about nurses being allowed to undertake SToP. Nursing staff also have a vital role to play in showing sensitivity towards women during the process.
A review of developments in medical termination of pregnancy

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A review of developments in medical termination of pregnancy

**Aim.** This literature review aims to supplement guidelines by providing an overview of recent evidence relevant to medical termination of pregnancy.

**Background.** Termination of pregnancy is available to women in the UK within legal parameters. Although guidelines form a strong body of evidence on which nurses and midwives can base their practice, there is a need to supplement them with up-to-date robust research findings.

**Method.** A systematic search of the literature with high sensitivity and low specificity was undertaken on five databases using medical subject headings (MeSH) terms including (medical) induced abortion, therapeutic abortion and termination of pregnancy.

**Results.** The literature search revealed articles under the following headings: The importance of choice for the women involved in the need for the optimal medication type, dose, route and interval between stages one and two, and the optimum place for medical termination to take place.

**Conclusion.** It was found that women attach a great deal of importance to the opportunity to choose their method of termination. The first stage of mifepristone is now a standard practice and an optimum dose has been determined. Several studies examined misoprostol used in the second stage of medical termination. There was some evidence for repeated doses of misoprostol, particularly in later gestation, with conflicting evidence on the optimal route. There were some grounds for reducing the interval between stages. Consideration should be given to home medical termination based on individual circumstances and choice. Gestation and previous obstetric history is an important factor to take into account when determining optimal regimen.

**Relevance to clinical practice.** The number of medical termination of pregnancies performed has risen in recent years together with the nurses’ involvement. As new research is published, it is imperative that nurses adapt to basc their involvement on the best available evidence.

**Key words:** medical induced abortion, medical termination of pregnancy, medical therapeutic abortion, midwifery, nurses, nursing

Introduction

Currently, termination of pregnancy (ToP) in England and Wales is confined to the legal parameters of English law. Although there have been numerous challenges to it from imposing greater or lesser restrictions, it remains politically contentious but is unlikely to undergo radical changes in the near future.
In addition to legislation, major guidance for the care and
treatment of women undergoing a ToP in the UK comes in the
form of the Royal College of Obstetricians and Gynaecologists
Guidelines (RCOG 2004). The guidelines are based on the
best available evidence at the time of publication; but as the
numbers of medical terminations have been rapidly increas-
ing, there have been several research developments which are
worthy of exploration to supplement available guidance.

Methods

A comprehensive electronic literature search was undertaken
using a high sensitivity and low specificity approach in an
effort to increase the breadth of research studies captured.
MESH terms used included therapeutic abortion, induced
abortion methods, medical abortion and ToP. The search was
limited to research studies and systematic reviews, and was
performed in CINAHL (32), Medline (73), Cochrane data-
bases (2), ISI Web of Knowledge (85) and Proquest (26). The
initial number of references obtained was 218. The abstracts
were scanned and the full text obtained if deemed to be
relevant. From the total number of full text research studies
obtained, an iterative approach was used by searching
their reference lists for further research studies revealing three
further studies. The search was restricted to English language
and to articles with the potential to supplement the RCOG

Results

Themes from the literature retrieved centred on issues such as
the choice of method particularly from the woman’s per-
spective. Among the medical termination of pregnancy
(MToP), the issue of optimal medication dose, timing of the
two phased approach, route of medication and the optimal
place for MToP procedure were the most commonly
researched topics.

Choice of method

The issue of choice in ToP is a recurring theme in the
literature. The RCOG guidelines advocate a minimum of one,
and ideally a choice, of the recommended methods for each
gestation band (RCOG 2004) (Table 1).

Table 1 Summary of abortion methods according to gestation band (RCOG, 2004)

<table>
<thead>
<tr>
<th>Week</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>Medical abortion using a single oral dose of the progestogen, medroxyprogesterone acetate, followed by a single dose of mifepristone (also known as mifepristone or misoprostol)</td>
</tr>
<tr>
<td>6-13</td>
<td>Surgical abortion by means of suction aspiration using electric or manual suction at gestations below 12 weeks. For gestations of 12 weeks or less, suction aspiration is surgery of gestation</td>
</tr>
<tr>
<td>14-20</td>
<td>Conventional suction termination using electric or manual suction under general anesthesia. The uterus is emptied using a suction curette. A follow-up test of pregnancy is not performed.</td>
</tr>
<tr>
<td>21+</td>
<td>Surgical abortion at later gestations using a combination of suction manually electric curette and soaked curette</td>
</tr>
</tbody>
</table>

Figure 4 Summary of abortion methods appropriate for use in ToP abortion services for women presenting at different
gestation bands.
A review by Ho of women’s perceptions lists the commonly given reasons for choosing medical or surgical abortion (Fig. 1). In a randomised controlled trial by Wong et al. (2006), two groups of women were either given a decision-aid or a control leaflet on contraception. There was no difference in method chosen, but the intervention group had a higher knowledge and lower risk perception score about both methods than the control group. Offering evidence-based written information would help to reduce unrealistic expectations outlined in Slade et al.’s study on women’s perceptions of care undergoing surgical termination of pregnancy (SToP) or MTP where many of the women did not anticipate such a severe physical response to the procedure (Slade et al. 2001).

In Denmark, women under nine-week gestation either chose (n = 922) or were randomised (n = 111) between MTP (600 mg of mifepristone followed by 1 mg gemeprost) and SToP (vacuum aspiration under general anaesthetic) (Rødbøe et al. 2003b). More women were satisfied or very satisfied after surgical than medical termination, both after choosing (92 vs. 82%) and randomisation (94 vs. 68%). Satisfaction was higher with choosing (82%) than with randomisation (68%) to MTP. The authors conclude that satisfaction with both methods is high and higher when given the choice.

A health technology assessment (Rødbøe et al. 2005a), summarising medical vs. surgical first trimester abortion associated with the article previously cited by Rødbøe (2005b), found that choice of method is important for patient satisfaction, but that organisations offering a choice are probably less efficient.

A US article by Masch and Roman (2005) outlines the choice of methods available, but recognises that MTP may not be offered because of the one million abortions performed in the US, 98% are surgical. However, a US multicentre study that offered women choice between MTP and SToP found that the overwhelming majority reported that they were somewhat or very satisfied with their chosen method, they would also recommend it to others and choose it again (Harvey et al. 2001).

The use of MTP in Germany remains relatively low; but in a recent study, 219 women opted for their preferred method of ToP (Hemmending et al. 2005). Comparing before and 1 month after ToP, the study results showed a significant decline in both anxiety and depression for both methods. The MTP group had significantly more side effects such as prolonged bleeding and pain, but this did not negatively influence the women’s coping. The vast majority of women valued being able to choose between methods as highly important to them.

A less recent, partially randomised trial compared MTP with SToP in women less than nine-week gestation (Henshaw et al. 1993). Women who expressed a preference were allocated to their chosen method and those who did not were randomly allocated either MTP or SToP. A follow-up study was undertaken by Howie et al. (1997). After contacting 80% of the original cohort, a total of 140 (39%) out of 363 women were surveyed. They were asked whether they would hypothetically opt for the same or a different method of ToP in the future. Seven women (11%) treated according to preference, compared with 20 (26%) of women who were allocated randomly, would opt for a different method in the future. Of the women allocated at random, six (13%) in the SToP group compared with 14 (36%) in the MTP group would opt for a different procedure in the future. This showed women were significantly less likely to opt for a different treatment method if they were treated according to preference and that SToP is significantly more acceptable than MTP when women were randomly allocated to a method. The main findings of this study echo those of the previous citations in that women attach a great deal of importance to the opportunity to choose their method of termination.

The procedure of medical termination of pregnancy

Following their use for induction of labour in 1968, prostaglandins were later used as “menstrual stimulants” (Fildes 1976). In 1991, the anti-progesterone mifepristone, in combination with a prostaglandin analogue, was licensed in the UK for ToP (Hamoda et al. 2005c) and is now used in over 30 countries (von Hertzen & Baird 2006). This comprises a two-stage process where the woman is administered mifepristone which interrupts the pregnancy by causing detachment of the fetus from the uterine wall and increasing uterine contractility (Fielding et al. 2001). The second stage involves administration of a synthetic prostaglandin such as misoprostol or gemeprost to produce strong uterine contractions (Fielding et al. 2001).
Medical termination of pregnancy requires a commitment from the woman to accept the second stage of treatment from her health care provider following the first stage of the termination. If the woman does not accept the second stage of treatment, there is a risk of the pregnancy continuing. Continuing a pregnancy following mifepristone is rare. A few cases of normal pregnancies and offspring have been reported (Sitruk-Ware 2006), but the risks associated with it include possible birth defects associated with both stages (Fielding et al. 2001, Ashok et al. 2002, Sitruk-Ware 2006).

In recent years, there has been much consideration of MToP efficacy, which includes research on the medication of choice, the dose, timing and route of delivery. The issue of where MToP should take place has also been the subject of research. The findings from these studies have the potential to progress MToP from a medically orientated procedure to a woman-centred service. This section will endeavour to evaluate what evidence is available to enhance development of a woman-centred service.

The medication of choice

Many pharmaceutical combinations have been used in MToP, and research findings have gradually refined the types of medication used. For example, although a 2001 US study used intramuscular methotrexate followed by two doses of 800-μg misoprostol vaginally 4-6 days later (Harvey et al. 2001), this combination is no longer advised. Mifepristone is currently the medication of choice for stage one of MToP (RCOG 2004). The second stage normally comprises administration of gemeprost or misoprostol. A retrospective study of 833 women admitted for first trimester abortion in Denmark received either gemeprost 1 mg (n = 410) or 800-μg misoprostol vaginally (n = 423) (Svensen et al. 2003). The authors found gemeprost and misoprostol equally effective with the two-week follow-up showing 99% complete abortion rate. In a prospective randomised trial comparing the efficacy and cost in the second trimester, 25/27 (92.6%) in the misoprostol group and 22/27 (81.5%) in the gemeprost group delivered within 48 hours (Azlin et al. 2006). The side effects were not significantly different between the groups. The mean cost per patient was considerably cheaper with misoprostol (US $1-48) compared with gemeprost (US $8-579).

Optimising the dose of medication

When first introduced, mifepristone 600 mg was advocated, but two recent systematic reviews showed that 200 mg is as effective as 600 mg (Kuhler et al. 2004, Manons 2006). One to three days after 200 mg of mifepristone orally, the RCOG guidelines (Table 2) recommend 800 μg of misoprostol vaginally up to nine-week gestation.

In an attempt to find the optimum dose of misoprostol, a Canadian multicentre randomised trial of 956 women less than eight-week gestation was undertaken (Shannon et al. 2006). Three groups were prescribed 200 μg orally, 400 μg orally or 800 μg vaginally of misoprostol. It was self-administered at home 24-48 hours following mifepristone with instructions to take a second dose at 24 hours if bleeding was less than a normal period. Successful abortion without surgery was 94.1% with no significant difference across the groups. Overall, 97.7% of the women took a second dose of misoprostol (group 1, 36.6%; group 2, 28%; and group 3, 92.9%). The side effects were not significantly different in complications between the groups, but the frequency of fever, headache and chills appeared to be dose correlated. Interpretation of effects should be cautious as bleeding was not in place. Nevertheless, the authors found that a lower dose of misoprostol given orally is likely to be as effective for women less than eight-week gestation (Shannon et al. 2006).

Ashok et al. (2002) studied 4132 consecutive women undergoing MToP for whom the overall complete abortion rate was 97.7%. The first 2000 women were administered mifepristone 200 mg orally followed by misoprostol 800 μg vaginally 36-48 hours later, which showed a significantly higher surgical evacuation rate with increasing gestation. For the latter 2132 women, the regime was changed adding a second dose of misoprostol if required. Following this modification, gestation ceased to have an effect on overall efficacy. There was no significant reduction in the surgical evacuation rate in women of lower or higher gestations, but the ongoing pregnancy rate fell from 0-6-0.1%.

An Indian randomised placebo controlled trial of 300 women at eight-week gestation or less, compared one or two doses of misoprostol 48 hours after mifepristone 200 mg (Goyal et al. 2007). The authors found that the additional oral dose of misoprostol 400 μg did not significantly increase the rate of complete abortion without surgical intervention, but reduced the number of continuing pregnancies from 7-1%.

A systematic review exploring the number of doses of misoprostol needed identified 26 studies, only three of which were randomised controlled trials, that measured the differing repeat doses of misoprostol (Gallo et al. 2006). They ascertained that the effect of repeated doses of misoprostol has not been definitively established.

Timing of the medication

The RCOG guidelines (2004) recommend misoprostol being administered 1-3 days after mifepristone up to nine-week
Table 2: Recommended medication regimen (RCOG, 2004)

<table>
<thead>
<tr>
<th>Medication Regimen</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Misoprostol 200 mg orally followed 1-3 days later by misoprostol 800 µg vaginally.</strong> The misoprostol may be administered by a clinician or self-administered by the woman. For women at 49-63 days of gestation, if abortion has not occurred 4 hours after administration of misoprostol, a second dose of misoprostol 400 µg may be administered vaginally or orally (depending upon preference and amount of bleeding).</td>
<td></td>
</tr>
<tr>
<td><strong>Oral administration of 600 mg of misoprostol every 4 hours for 3-4 days.</strong> The misoprostol may be administered by a clinician or self-administered by the woman. For women at 49-63 days of gestation, if abortion has not occurred 4 hours after administration of misoprostol, a second dose of misoprostol 400 µg may be administered vaginally or orally (depending upon preference and amount of bleeding).</td>
<td></td>
</tr>
</tbody>
</table>

Based on available evidence, the following regimen appears to be optimal for early medical abortion up to 9 weeks (63 days) of gestation. This advice is based on the considerations of efficacy, adverse-effect profile, and cost.

- **Misoprostol 200 mg orally followed 36-48 hours later by misoprostol 800 µg vaginally.** A maximum of four further doses of misoprostol 400 µg may be administered at 3-hourly intervals, vaginally or orally (depending on the amount of bleeding).
- For mid-trimester abortion (13-24 weeks of gestation), medical abortion with misoprostol followed by prostaglandins is an appropriate method and has been shown to be safe and effective.
- For mid-trimester medical abortion, a dose of 200 mg of misoprostol is adequate.

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Based on available evidence, the following regimen appears to be optimal for mid-trimester medical abortion. This advice is based on the considerations of efficacy, adverse-effect profile, and cost:

- **Misoprostol 200 mg orally followed 36-48 hours later by misoprostol 800 micrograms vaginally.** A maximum of four further doses of misoprostol 400 micrograms may be administered at 3-hourly intervals, vaginally or orally (depending on the amount of bleeding).
- For mid-trimester abortion (13-24 weeks of gestation) medical abortion with misoprostol followed by prostaglandins is an appropriate method and has been shown to be safe and effective.
- For mid-trimester medical abortion, a dose of 200 mg of misoprostol is adequate.

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- **Oral administration of 600 mg of misoprostol every 4 hours for 3-4 days.** The misoprostol may be administered by a clinician or self-administered by the woman. For women at 49-63 days of gestation, if abortion has not occurred 4 hours after administration of misoprostol, a second dose of misoprostol 400 micrograms may be administered vaginally or orally (depending upon preference and amount of bleeding).

*This regimen is unlicensed.*

Repeat administration of misoprostol was required in 23 women (11%) and eight women (4%) in the two groups. These results led the authors to conclude that the 6-hour regime is not as effective as the 36-48-hour regime.

**Route of administration**

Hamoda et al. performed two randomised trials to ascertain whether misoprostol following misopropstine was as acceptable and effective sublingually as vaginally in medical abortions up to 13-week gestation (Hamoda et al. 2005a) and from 13-20 weeks (Hamoda et al. 2005b). The findings...
from both studies view sublingual (SL) misoprostol as an acceptable and effective alternative to vaginal (V) administration. In the up to 13-week study, 3/158 (1.9%) (SL) and 4/156 (2.6%) (V) required SToP (Hamoda et al. 2005a) and in the 13–20-week study, three women (8.3%) from the SL group and one woman (2.5%) from the V group required surgical evacuation (Hamoda et al. 2005b). There was a greater likelihood of requiring stronger analgesia via SL route in the 13–20-week study (Hamoda et al. 2005b) and of more prostaglandin side effects via the SL route up to 13-week gestation (Hamoda et al. 2005a). Over two-thirds of women in both studies expressed satisfaction in the route of administration, both sublingually and vaginally.

A large multinational study by the World Health Organisation was established to ascertain the most effective route of misoprostol three days following mifepristone 200 mg (WHO Research Group on Post-ovulatory Methods for Fertility Control 2003). Three treatment groups of 2173 women were administered either oral misoprostol 800 μg and V placebo followed by oral misoprostol 400 μg twice daily for seven days (O/O), or V misoprostol 800 μg and oral placebo followed by oral misoprostol 400 μg twice daily for seven days (V/O) or V misoprostol 800 μg and oral placebo followed by oral placebo twice daily for seven days (V only). The authors found that up to eight week gestation there was no difference in complete abortion percentages between the three methods. However, at eight week and above, the V/O (96.6%) was more effective than the O/O route (94.5%) and the V only route (95.4%) (WHO Research Group on Post-ovulatory Methods for Fertility Control 2003). The duration of bleeding was similar in all three groups and was not decreased by continuing misoprostol over seven days.

A small UK study of 89 women assessed acceptability of self-administration of V misoprostol (Kiran et al. 2006). The dose of misoprostol ranged from 800 to 4000 μg with 100% complete abortion rate. A total of 60 (67.4%) did not mind and 13 (14.6%) preferred self-administration. Only 34 women (38.2%) would have been willing to use this method at home.

Discussion

Any decision that a woman makes during this procedure is likely to be challenging emotionally and when choice is given the studies summarised above show that it is valued by women. However, in the UK, there are often practical constraints on offering choice of methods, for example, limited theatre time or clinic facilities. Interestingly, it appears that the method chosen does not seem to be as important as the need to be offered a choice (Howie et al. 1997, Roedby et al. 2005b; Wong et al. 2006). A point worthy of note is that organisations offering a choice are likely to be less efficient (Roedby et al. 2005a).

Choosing the right medication and dose is crucial and mifepristone 200 mg orally is the dose of choice internationally (Kulzer et al. 2004, RCOG 2004, Marions 2006). Gemeprost as the second phase medication is being superseded by misoprostol because of lower cost, stability at room temperature and the option of oral administration (Svensen et al. 2005). From the research studies outlined on misoprostol dose, it appears that the optimal dose is dependent on gestation (Ashok et al. 2002, Shannon et al. 2006). Repeated administration of misoprostol, increasing the dose until evacuation occurs avoiding an initial high dose of misoprostol would be a common sense approach. However, Gallo et al. (Gallo et al. 2006) in their systematic review argue that
the effect of repeated doses of misoprostol has not been established and that a large sample size would be needed to assess an increase in marginal effect. They assert that measuring time to expulsion would be a useful outcome measure to determine when and whether a repeat dose of misoprostol is necessary (Gallo et al. 2006). There is some evidence for repeating the dose particularly in later gestations, but this would increase the cost and inevitably increase the length of hospital stay.

If the interval between the first and second stage of MTOP could be reduced, and the two stages of medication more contiguous, this would reduce the time of anxiety and uncertainty for the woman as well as increasing the efficiency and decreasing the cost of this method. The research to date appears to support reducing the interval between stages from 48–24 hours (Schaff 2006), but the option to reduce the interval to 6–8 hours should be adopted with caution (Schaff 2006, Guest et al. 2007).

The standard route of administration for misoprostol is oral (RCOG 2004), but the optimum administration routes for misoprostol is still being researched. Interestingly, in the studies by Hamoda et al. (2005a,b), the SL and V route were equally satisfactory for the women. Acceptability for staff was also the same for both routes. Given the intrusive nature of V insertion and the additional time necessary for this route, as long as effectiveness is not compromised the oral or SL route would be the sensitive choice.

Effectiveness of misoprostol did not appear to be compromised based on route in the studies by Hamoda et al. (2005a,b) who found SL as effective as the V route. However, a much larger international study found that at 8-week gestation and above, V followed by oral administration of misoprostol over seven days was the most effective (WHO Research Group on Post-ovulatory Methods for Fertility Control 2003). It is not possible to determine the exact cause of the difference in findings, but it could lie in the small size of Hamoda et al.’s studies (2005a,b) or in the difference in action between the effectiveness of SL and oral administration of misoprostol (von Hertzen & Baird 2006).

In appropriate circumstances, allowing women to abort at home would save resources. However, despite the majority being successful in undertaking self-administration, in both the Kiran et al. (2006) and the Hamoda et al. (2005c) UK studies, there was a reluctance by women to undertake the same self-administration at home; this is despite a Canadian study (Shannon et al. 2006) and several US studies (Schaff et al. 2000, Schaff 2006) which showed that it can be successfully achieved. The issue of home circumstances such as support for the woman or potential intrusion as well as ease of access to emergency services would need to be taken into account in making a decision as to the viability of home MTOP.

Based on current evidence, it appears that MTOP is becoming a more frequently used method of ToP which is gaining acceptability by clinicians and clients. Intensive research has resulted in the refinement of the medical regime and as it becomes more streamlined it is likely to become the treatment of choice for many. Nevertheless, there are limitations on the applicability of the findings from the literature as the studies examined differing populations by way of gestation and gravida, interventions in the form of differing medication regimen and differing outcomes.

Conclusion

Since the introduction of the RCOG guidelines, there have been many advances in the field of MTOP and this paper sought to supplement the available guideline evidence. Major themes of the studies were the importance of choice for the women involved, the need for the optimal medication type, dose, route and time interval between stages one and two. Finally, the correct location for the MTOP procedure was examined.

The studies outlined highlight the best evidence available and provide detail for clinicians to optimise care for women undergoing MTOP. Nevertheless, each woman attending for MTOP should have a plan of care based on her own individual needs based on, and not enslaved by, best available evidence.

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Contributions

Study design: AL; data analysis: AL and manuscript preparation: AL.

References


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REVIEW

A review of termination of pregnancy: prevalent health care professional attitudes and ways of influencing them

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A review of termination of pregnancy: prevalent health care professional attitudes and ways of influencing them

Aim. To review the literature on attitudes of health care professionals to termination of pregnancy and draw out underlying themes.

Background. The controversy surrounding therapeutic abortion is unremitting. Public opinion often polarized and unyielding. Nurses and midwives are at the centre of this turmoil, and as more termination of pregnancies are being performed using pharmacological agents, they are becoming ever more involved in direct care and treatment. Attitudes towards termination of pregnancy have been found to vary depending on the nationality of those asked, the professions involved, experience in abortion care, as well as personal attributes of those asked such as their obstetric history and religious beliefs. The reasons for women undergoing abortion were also found to influence attitudes to a greater or lesser extent.

Conclusion. This paper explores research studies undertaken into attitudes of health care professionals towards termination of pregnancy, to appreciate the complexity of the debate. It is possible that the increased involvement of nurses in termination of pregnancy, that current methods demand, may lead to change in attitudes. Consideration is given to a number of remedies to create an optimum environment for women undergoing termination of pregnancy.

Relevance to clinical practice. This paper establishes via a literature review that attitudes in those working in this area of care depend upon a variety of influences. Suggestions are made for measures to be put into place to foster appropriate attitudes in those working in termination of pregnancy services.

Key words: attitudes, induced abortion, midwifery, nursing, termination of pregnancy, therapeutic abortion

Introduction

Termination of pregnancy is unique as an area of practice in that health care professionals are unlikely to be able to separate their own attitudes from the care that they deliver. Therefore, it could be argued that attitudes held by health care professionals, whether positive or negative, will have a profound impact on the quality of care a woman undergoing termination of pregnancy will receive.

Despite national guidelines (RCOG 2004), there remain numerous examples of patchy termination of pregnancy services in the UK. Internationally, services also vary between
and within countries with complex laws and even more complex historical and cultural influences. Against this background, nurses face distress daily as they support women through the traumatic experience of termination: risking protest if they become involved in termination and discrimination if they refuse. Recent advances have resulted in less surgical terminations (SToP) normally performed by doctors and more medical terminations (MToP) performed with the use of pharmacological agents, commonly administered by nurses. Consequently, nurses are becoming directly involved in terminations accentuating the need for sensitivity in the care they give. For ease of writing, the term ‘nurse’ will be used throughout to describe all those in the nursing professions including midwives.

Twenty years ago, as nursing involvement in prostaglandin (or medical) ToP began, it was associated with reluctance by nurses to engage with this process (Webb 1984, Allen 1985). With the recent and continued rise in the number of MToPs, these findings were portentous of current concerns in this area, and it is unclear how the new emphasis on nursing intervention in abortion will affect the dynamics of the nurse-patient relationship. This paper will explore the findings of research studies undertaken into attitudes of health care professionals towards termination of pregnancy, to anticipate and minimise potential difficulties of increasing nurse intervention.

It is worthy noting at this point that reviewing the evidence of attitudes towards such a sensitive topic raises several difficulties for the author. Inevitably, personal values and judgements are present, but an effort has been made to minimise emotive language. To represent the evidence accurately, the terms employed by the original authors are used.

**Aim**

The aim is to review the literature on attitudes of health care professionals to termination of pregnancy and draw out underlying themes. This analysis will add clarity to a complex issue and inform the ongoing debate regarding appropriate care for the women involved.

**Methods**

A comprehensive electronic literature review was undertaken using a high-sensitivity and low-specificity approach. This type of search increases the breadth of research studies captured, but may be unsuitable for commonly researched topics as it is likely to yield large numbers. MESH terms used included ‘therapeutic abortion’, ‘induced abortion’, ‘medical, surgical termination of pregnancy’, ‘staff attitudes’ and ‘attitudes’. The search was limited to research studies and was performed in CINAHL (41), Medline (91), Biomed Central (39), Proquest (70) and Sage online full-text publications (63). The initial number of references obtained was 334. The abstracts were scanned and the full text obtained if deemed to be relevant. From the total number of full-text research studies obtained (19), an iterative approach was used by searching their reference lists for further research studies revealing a further six studies. The authors of three studies were contacted to ascertain whether they had any more recent data published elsewhere, but none responded positively. No language or date restrictions were employed and although some of the studies obtained were dated and they were included as they are seminal studies or act as a comparator with present day findings.

**Results**

An initial review of the research retrieved showed that attitudes towards termination of pregnancy vary depending on the nationality of those asked, the professions involved, experience in abortion care, personal attributes of those asked such as their obstetric history and religious beliefs. The reasons for women undergoing abortion were also found to influence attitudes to a greater or lesser extent. These influences will now be examined in turn with some suggestions for practice on how to optimise attitudes of those working in abortion services.

**Nationality of research participants**

The nationality of research participants appears to affect attitudes to abortion. For example, from 1993–1999, seven people were killed and 17 wounded in the USA in abortion-associated attacks (Ventura 1999). This level of violence and the message it sends inevitably has an effect on staff attitudes. Ventura found, in her survey of registered nurses in the USA, that attitudes such as an unwillingness to participate in abortion had hardened since the last survey a decade before. In 1988, 48% said that they would refuse to work in a unit where abortions were performed and in 1998, 61% stated that they would refuse.

These findings on nurses’ attitudes are echoed in a US medical study, where doctors were increasingly reluctant to participate in ToP (Fischer et al. 2005). A study by McKee and Adams (1994) was designed to elicit attitudes of US nurse-midwives towards undertaking legal abortions because of the national shortage of physicians willing to undertake the procedure. Of 1028 questionnaires, 71% were returned.
and they ascertained that 79% of respondents would not support federal or state efforts to limit access to abortion. Fifty-two per cent (possibly) would vote in a secret ballot to permit the performance of abortion by certified nurse-midwives. The lowest level of support in the US came from the mid-west (30%) and south-east (41%) and the greatest from the west coast (65%). These results highlight that its diverse demographics and culture preclude viewing US research results as homogenous and representative of the nation. Alternatively, Shotorbani et al.'s (2004) study in the US demonstrated that 76% of 312 medical, physician assistant and nursing students supported the availability of legal abortion in any circumstances. Sixty-four per cent were willing to attend abortion instruction during their training.

Another US study by Kade et al. (2004) explored the effect of staff attitudes on abortion. This small, qualitative piece of research on 17 doctors and three nurse managers involved an open-ended postal survey. They found that, although no abortions had been cancelled, more than one-third of doctors' stated abortions had been postponed because of lack of nursing staff. Two nurses stated it was more difficult to schedule abortions than other procedures. Generalisation from this study is limited because of its qualitative nature and as there were only three nurses in the sample, but it underscores Ayer et al.'s (1999) paper where they found a significant correlation between attitude and practice scores in a mailed questionnaire to 152 obstetricians and gynaecologists. They expressed concern that if fewer professionals become involved in termination, it will leave access to abortion, particularly for the disenfranchised, in jeopardy.

In contrast to the US studies, in a postal semi-structured questionnaire sent to a Swedish random sample of 258 midwives and 269 gynaecologists in 1998 the vast majority supported the Swedish legislation in which the woman can terminate her pregnancy before the 18th week without giving any grounds (Hammarstedt et al. 2005). Interestingly, researchers found that the longer the experience in abortion care, the more liberal the views of nurses and gynaecologists. They assert that these views are more liberal than previous studies although the data were collected in 1998 for this 2005 publication (Hammarstedt et al. 2005).

As part of a larger study of attitudes of health care professionals towards abortion Rakhadu et al. (2006) explored the views of eight traditional healers in South Africa. As influential members of the rural communities where the study took place, their pro-life views and traditional ceremonies had not been taken into consideration when formulating the ToP law, possibly leading to local antipathy towards women seeking abortion.

A UK study by Marshall et al. (1994) involved a convenience sample of 84 nurses of all grades including students who were tested via a questionnaire survey for, amongst other variables, ethnicity and attitude towards abortion. African respondents had the highest mean attitude scores and Chinese the lowest but the groups were too small to test for significance. Afro-Caribbean nurses were found to have a significantly lower attitude score than Caucasian nurses.

Different professional views

In a Danish survey of 993 of health care professionals in gynaecology, a 76% response rate showed an overall more liberal attitude towards abortion among gynaecologists than among midwives and nurses. For example, legal abortion was acceptable without reservations to 95% of gynaecologists, 84.9% of midwives and 77.8% of nurses (Fonnest et al. 2000).

A study evaluating a programme directed at increasing the motivation and skills of nurses, social workers and other professionals serving the poor in TN, USA was performed over 30 years ago (Hendershot & Grimm 1974). They found that social workers had a more liberal attitude towards abortion than nurses. The researchers claim that this could be because of the differing "normative orientations" of the groups Social workers see the client under normal life conditions enabling the client to cope in problem situations and able to evaluate the long-term consequences; whilst nurses focus directly on health impairments and the short-term effects of abortion (Hendershot & Grimm 1974).

Eighty-two per cent of 702 British GPs in a random survey by Francombe and Freeman (2000) were broadly pro-choice and 18% broadly opposed abortion. The survey had a 71% response rate, included 25% women and 92% of respondents had children. Interestingly, two-thirds of doctors who were anti-abortion supported the Abortion Act. However, a quarter of those broadly anti-abortion did not believe GPs needed to reveal their stance to women. The authors claim that UK law paved the way for other countries with regard to abortion law but now lags behind many countries where a woman may obtain an abortion in the early months without any reason being given (Francombe & Freeman 2000).

Experience in termination care

In the study by Marshall et al. (1994), an adaptation of Stegoff's (1976) attitude to abortion scale was used. A survey of 84 nurses in three clinical settings found that those working in gynaecology had significantly lower attitude scores than those working in medical or surgical wards.
The questionnaire included positive and negative statements on moral, social, birth control, health, foetal and women’s rights issues. The length of time nurses had spent in the area also affected attitudes and those who had spent over six years on a gynaecology ward had a statistically significant lower attitude score than those who had never worked on gynaecology. These findings contrast with those of the Danish study by Hammarstedt et al. (2005) which showed the more experience of working with women undergoing legal abortion, the more liberal the views of midwives and gynaecologists for example in viewing abortion as a failure of the woman, man or health system.

Personal attributes of staff

The study by Hammarstedt et al. (2005) involving midwives and gynaecologist revealed that one in five of the female respondents had experienced an abortion and one quarter of male respondents had a partner or close friend or relative who had undergone an abortion. This finding highlights that attitudes of professionals could well be tempered by direct and indirect personal experiences of ToP.

Religion was found to be a prominent attribute in several research studies exploring attitudes towards abortion. Forrester et al. (2000) showed a strong association between the sex and age of the gynaecologists and nurses and degree of religious belief affecting attitudes towards abortion, although 77.8% stated that legal abortion is acceptable without reservations up to 12-week gestation. The majority of a sample of nurses in the study by Marshall et al. (1994) who declared some religious affiliation had more negative attitude scores than those who did not, or were agnostic.

In a 30-year-old US study of nurses and social workers, researchers statistically controlled variables of age, sex, race and social class (which may have distorted attitudes) to find that members of liberal church bodies approve of abortion more than do members of fundamentalist church bodies (Hertel et al. 1974). It was found that there was also a strong relationship between church attendance and attitudes towards abortion, with those attending more frequently having a more negative attitude. However, contrary to the hypothesis this did not differ between those of liberal and conservative religions. The participants comprise the same sample used by Henderson & Grimm (1974).

Mansfield and Soudry (2000) performed a survey into attitudes towards abortion and euthanasia of 139 international nurse/midwives attending a conference in Israel. They found a relationship between positive attitudes towards legalisation of euthanasia and abortion, but no link between religious affiliation and abortion attitudes was stated.

Termination criteria

Staff attitudes appear to alter depending upon the circumstances of the woman seeking the termination such as weeks of gestation and reason for the termination. In a US study (Koslowsky et al. 1976), 40 physicians from obstetrics and gynaecology and 25 doctors of family medicine were asked about their attitudes towards abortion. Physicians in both specialties ranged from high rates of approval for medical reasons to lower rates of approval for socio-cultural, non-medical reasons except where pregnancy resulted from rape or incest. A more recent study on 82 (53% response rate) physicians in the Bronx, USA echoes these findings (Aiyer et al. 1999). In addition, those who would or do include abortion in their practice had supportive attitude scores.

The woman’s right alone to choose before 12-week gestation was indicated as appropriate by 46% of a sample of 702 General Practitioners in a UK survey by Fencombe and Freeman (2000). Paradoxically, 63% of the doctors also thought that two doctors’ signatures should be required. In Hammarstedt et al.’s study, 89% of those who had working experience of abortion stated that the woman herself should decide whether or not to have a legal abortion (Hammarstedt et al. 2005).

Circumstances which caused nurses to be sympathetic towards abortion included the woman’s mental and physical health being at risk, rape or foetal disorder in the study by Marshall et al. (1994). Teenage pregnancy, genuinely failed contraception and socioeconomic reasons received a less positive response. Most respondents stated that they would not refuse to be involved in terminations (70%), but those who would refuse cited late and repeat terminations, as well as choosing the gender of the foetus as reasons.

A recent US survey by Marek (2004), with 75 labour suite nurses, observed that in the first trimester 95% of nurses would care for a woman undergoing termination for foetal demise, 77% for foetal anomalies incompatible with life and 37% for non-lethal anomalies. These results show that nurses were more willing to assist in serious situations, but this willingness lessened with each trimester indicating the importance of gestation in abortion care. Interestingly, Marek (2004) found that nurses who participated in ToP as well as those whose refusal had been criticised by their co-workers highlighted the turmoil surrounding this contentious issue.

The attitudes of 310 obstetrics and gynaecology residents in Philadelphia, USA towards participation in abortion for foetal conditions were evaluated via a directly distributed questionnaire (Fischer et al. 2005). The 148 completed questionnaires confirmed Marek’s findings in that willingness
to be involved in abortion reduced with decreasing foetal anomaly and increasing gestation. The research had several limitations, for example, it did not examine maternal health and relied on opinion rather than actions; nevertheless, the findings support similar studies outlined such as the study of medical students at the University of Birmingham. Researchers found that medical students’ willingness to be involved in abortion provision was related to the stage and the circumstances of pregnancy (Bates et al. 2006). Fifty-seven per cent of the sample in the study by Marshall et al. (1994) also stated that their attitude towards termination of pregnancy altered depending on the length of a woman’s gestation.

Discussion

The international studies reviewed show a range of differing attitudes contingent on the cultural context. In a shrinking world with migrant populations, it is increasingly likely that nurses will care for women from overseas undergoing Top. In this case, they have an obligation to provide care which is culturally sensitive appreciating the traumatic psychological and even physical journey many may have undertaken prior to the procedure.

The literature review found differences in attitudes between professions and the past and current diversity of education programmes have no doubt contributed to the differing formulation of attitudes. For example, the US study by Shotterberg et al. (2004) found strikingly that high proportions of health science students indicated an intention to provide abortions in their practice. However, from the little research undertaken in this area, nurses appear to have a less-favourable attitude towards abortion than other professionals and whilst worthy of note, these differences need to be explored to a greater extent in a contemporary health care context before any reliability can be placed on this assertion. Interprofessional education may provide a long-term solution to this issue.

The contradictory findings in the two studies examining attitudes and length of experience in abortion care reveals uncertainty as to whether attitudes are likely to change with experience. The issue of nurses not working in Top having more positive attitudes (Marshall et al. 1994) can be misleading as it remains hypothetical and does not reflect contemporaneous care. To ascertain whether attitudes change over time, a longitudinal study in Top care is required. In the meantime, staff working with women undergoing termination should be alert to their own and their colleagues’ potential to burn out. Practical measures to monitor morale and predict a change in attitudes could include regular personal reviews and guided reflection.

One study found that several of those caring for women undergoing Top had, themselves, undergone the procedure or knew someone who had. This highlights the need for sensitivity in this area of practice as professional views held could well be tempered by direct and indirect personal experiences of Top.

In line with the UK being more ethnically diverse, it is likely that religious influences on attitudes towards termination will become more multifactorial than those outlined in the studies reviewed. As Wahlberg (2007) explains, a variety of religions are shaping society’s views. As it is likely that those undergoing abortion as well as those working in the service in the UK will reflect this diversity, the challenge for care is to accommodate the differing beliefs of both women and staff sensitively and appropriately.

The studies reviewed show, somewhat predictably, that staff attitudes towards termination decline with the length of gestation. With the advances of home pregnancy testing kits, improved access to and more liberal sex education as well as early scanning techniques the majority of abortions are performed below 12-week gestation (RCOG 2004). Despite this, there will always be women who request a relatively late termination for legitimate reasons.

Conclusion

The preceding literature review has helped to inform the past and current status of attitudes towards abortion. However, the review suffers from several limitations in that some of the research is dated; much of it is derived from outside the UK, particularly the USA where views on this topic tend to be more radical. Some of the research relates to health care workers not directly involved with abortion and many of the studies ask for participants’ opinions rather than directly measuring practice. These factors limit the interpretation and application of much research in health care generally, but within these constraints, certain issues have been raised as pertinent to those in practice. From the literature, it appears that attitudes of staff towards abortion in the UK lie somewhere between the polemic rhetoric of the USA and the more liberal stance of some Scandinavian countries.

Differences in attitudes between professionals working within abortion services were found; although it is not certain whether attitudes remain constant, or change over time. The personal attributes of staff were found to be influential on attitudes, particularly religious beliefs. The reasons for undergoing abortion and the length of gestation were also found to affect attitudes towards abortion. All of the above are important influences on the service provided.
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CLINICAL FEATURE

KEYWORDS Abortion / Abortion legislation / Termination of pregnancy / Operating department / Conscientious objection

CLINICAL FEATURE

Provenance and Peer review: Unofficial submission; Peer reviewed.

Abortion: implications for theatre staff

by Dr Allyson Lipp
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Abortion is controversial and often sparks polemic debate. Nevertheless, theatre staff need to know the different methods of abortion, to be aware of the current UK legal position and possible future directions. Theatre staff must be mindful of their own ethical and emotional position in order to play a vital role in making women attending for this surgery feel at ease during such an emotionally charged event.

Introduction

The issue of abortion is contentious. It challenges those involved emotionally and ethically and although in the UK it is not within legal parameters, it remains controversial. Nevertheless, Operating Department Practitioners (ODPs) will inevitably care for, or at least encounter, women undergoing the procedure.

Methods of abortion

For the purposes of this article, the term ‘abortion’ will be used rather than ‘termination of pregnancy’, although they can be used interchangeably. There are two main methods of abortion: medical and surgical. Surgical abortions usually take place in theatre, whereas medical abortions normally occur on the ward. If a medical abortion fails, the woman may need to attend theatre for evacuation of retained products of conception. The types of abortion available at particular gestation bands are shown in Table 1. It performed during the first trimester both medical and surgical abortions are relatively safe procedures for the woman (RCOG 2004).

A systematic review was undertaken into the relative effectiveness of medical and surgical abortions (Say et al 2002). Both methods were found to be safe and effective, but the studies were too small to show whether either method was superior. It is not too much the method per se but the issue of choice of method which is important for the woman (Rothiey, Norgard & Nihas 2006). The woman is in a vulnerable situation and may feel that she has little control over her circumstances. Exercising control over the method of abortion, within gestation limits, has been shown to increase levels of acceptability and was valued by 140 women in a two year follow-up trial (House et al 1997).

Current UK legislation and future directions

Unlike other healthcare procedures provided under the NHS, a woman does not have a right to an abortion. It is only permitted on specific legal grounds (see Table 2). The Abortion Act was introduced in 1967 and has since been amended (HMSO 1982). Abortion is rarely out of the news and recently poor access to abortion services have been highlighted (NHS 2007) with an undercover investigation claiming that some women are forced into seeking illegal abortions in the UK (Harlow 2007). This issue, among others, prompted a recent House of Commons Science and Technology Committee which investigated whether the limitations imposed by the Act are appropriate given the advances in the evidence base (House of Commons Science and Technology Committee 2007).

The Committee heard from international experts associated with abortion and accentuated a mass of international evidence on the procedure. The government response to the committee highlighted many changes, seven of which could impact on the role of the operating department staff (Secretary of State for Health 2007). Some of these changes will require amendment to the current legislation but are likely to be implemented in the future.

In the future, nurses and midwives may be able to sign the HS10 form, a form currently needing the signature of two doctors which...
Unlike any other healthcare procedure provided under the NHS, a woman does not have a right to an abortion

Table 2 Legal grounds under which abortion can be performed (Abortion Act 1967)

A. The continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.
B. The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.
C. The pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.
D. The pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the existing children of the family of the pregnant woman.
E. There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

leads to delays in women accessing abortion services (Secretary of State for Health 2007). Nurses and midwives may also be able to prescribe the medication necessary to induce abortion as in many cases they already administer them. The government response to the committee, made radically, suggests that “subject to the usual training and professional standards nurses (and midwives) could be permitted to carry out early-surgical abortions” (Secretary of State for Health 2007, p8).

Non-medical providers of abortion

UK legislation dictates that surgical abortion can only be undertaken by a medical practitioner. Subject to an amendment, nurses, midwives and possibly ODPs could perform first trimester surgical abortions. Recently it was argued that English law already allows registered nurses to perform surgical abortion so long as a medical practitioner is in charge (Alger & Penny 2007). The paper argued in a detailed and cogent way and although its findings were questionable, it raised the issue that much current practice is based on outdated guidance which was developed before abortion techniques became so refined.

In some countries abortion is commonly performed by non-medical staff with no difference in effectiveness. A US study involving 1,365 women compared complication rates after surgical abortions performed by physician assistants and those performed by physicians (Goldman et al 2004). Total complication rates were slightly less in the physician assistant group (22 per 1,000 procedures) compared to the physician group (25.3 in 1,000). In the physician assistant group there were more incomplete abortions and in the physician group the most common complication was infection not requiring hospitalisation.

As with many other areas of practice previously classified as the doctor’s domain given the correct legal amendments, non-medical practitioners could be running their own abortion theatres in the future.

Meeting the needs of staff in the operating department

The ethics of abortion are complex and different ethical theories view abortion differently. For example, a utilitarian view would focus on the greatest good for the greatest number (Johnstone 2005). Thus, utilitarianism could sanction abortion as being better for society as a whole by reducing the birth rate and reducing the social and financial burden of caring for severely disabled infants. Another major ethical theory is deontology, which is duty-oriented and sees the matter as ‘what you would be doing by’. It is a duty to preserve life and potential life then this should remain a general principle, and therefore abortion would never be the right choice in any circumstances (Johnstone 2005).

Ethical theories can be quite tangle and challenging to apply in real-life individual situations where application of general maxims could lead to insensitive care. Jones and Chavner (2007) approach the ethics of abortion from a practical perspective. They reason that either one believes that the foetus has a moral status (and in that case abortion is morally wrong) or that the foetus has no moral status (and therefore abortion is not wrong). This seems like a simple matrix test. But when gestation or the pregnancy is added to the debate, as well as other issues that will influence individual situations, such as foetal abnormality and the woman’s versus father’s rights, it becomes an emotional and moral minefield.

The moral and emotional challenges of abortion were recognised in the Abortion Act (HMSO 1967) and it is one of the few procedures that allows for staff to conscientiously object to participating in treatment. Conscientious objection does not extend to participating in care surrounding the termination of a woman undergoing an abortion, or an emergency should arise (NMC 2006). Drissen and Cook (2000) assert that nursing and medical students cannot object to being educated about procedures in which they would choose not to participate (Drissen & Cook 2000). In reality any students who expressed a conscientious objection before or even during a theatre list would be given the option to leave. To avoid any negative impact on patient care it would be advisable for the number of staff to register any conscientious objection to their manager in advance of any specific situation (Nutall 2007).

In a study on nurses’ attitudes towards abortion, Marek (2004) found that nurses were isolated by their coworkers both when accepting and refusing to care for women undergoing abortion. This puts

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Meeting the needs of women in the operating department

Even staff who consistently object are likely to encounter women undergoing abortion, be it in the context of the recovery phase or during an emergency. When someone is in need of care, they deserve consideration and respect. To ensure humane and sensitive care it is the responsibility of the operating department, not to act out of their own beliefs, but to maintain the women's safety during the procedure. It is important that the practitioner is aware of up-to-date evidence in the field. Most concerns will normally have been dealt with prior to surgery, but in the perioperative phase the women may be concerned about her future fertility or whether she is more at risk of breast cancer as a result of having an abortion (Table 3). The women may also request further information on abortion and knowing the organisations which can help with future contraception and counseling would be useful (Table 4).

Just being there for a woman when she is undergoing an abortion is as important as being skilled and knowledgeable. In a study on patient perceptions of care during medical abortion (Glode et al 2001), the importance of positive staff attitudes was seen as paramount by the women and there is no reason to think that this would not apply to surgical abortion. Women coming to theatre for this procedure are

Figure 1: Methods of abortion available according to gestation (RCOG 2004, p65)

Table 5: Risks associated with surgical abortion (RCOG 2004)

Although a very safe procedure all operations carry a small amount of risk and those associated with surgical termination are:

- Excessive bleeding (haemorrhage) happens in around one in every 1,000 abortions.
- Damage to the neck of the womb (cervical trauma) happens in around one in 1,000 termination operations.
- Hole in the womb (uterine perforation) happens around four in every 1,000 termination operations.
- Up to one in 10 risk of infection (reduced by taking antibiotics).
- In one in every 100 abortions the womb is not completely emptied of its contents and further treatment may be needed.
- Future fertility - future fertility will not be affected if there are no problems with the abortion. It may be affected if a serious infection occurs.
- There is a slightly higher risk of future miscarriage or early birth.
- Breast cancer - no increased risk.
Theatre staff need to be aware of the two main methods of abortion as a knowledge of the risks will ensure optimum perioperative care.

Table 4 Contact details of UK organisations which may be of use to patients

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPAS (a registered charity offering consultation including emergency contraception, sexual health and abortion)</td>
<td><a href="http://www.bpas.org.uk">www.bpas.org.uk</a> 0845 304030</td>
</tr>
<tr>
<td>Brock Advisory Centres provide information on contraception and sexual health for young people</td>
<td><a href="http://www.brock.org.uk">www.brock.org.uk</a> 0800 0185023</td>
</tr>
<tr>
<td>Marie Stopes International is a registered charity offering consultation including emergency contraception, sexual health and abortion</td>
<td><a href="http://www.mariestopes.org">www.mariestopes.org</a> 0845 3008090</td>
</tr>
<tr>
<td>The Family Planning Association is a registered charity to enable people in the UK to make informed choices about sex and to enjoy sexual health</td>
<td><a href="http://www.fpa.org.uk">www.fpa.org.uk</a> 0845 3228690</td>
</tr>
</tbody>
</table>

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